State of Montana
Office of the Legislative Auditor

Performance Audit

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Medicaid Administrative Support Functions

This report contains conclusions and recommendations for changes in the operation and management of the administrative support functions of the Medicaid program. The recommendations include:

- More closely monitor the operation and output of the automated claims processing and reporting system.
- Examine ways to more adequately project AFDC caseload.
- Monitor service and cost data to ensure budget assumptions are reasonable.
- Assign staff for an adequate level of review of Medicaid activity and budget analysis.

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The Legislative Audit Committee
of the Montana Legislature:

This is our performance audit of the Medicaid Administrative Support Functions of the Department of Social and Rehabilitation Services.

This report contains conclusions and recommendations concerning department procedures in relation to Medicaid administration. Department responses are contained at the end of the report.

We wish to express our appreciation to the staff of the department for their cooperation and assistance.

Respectfully submitted,

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SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

The following is a listing of conclusions and recommendations of our performance audit of the Administrative Support Functions of the Medicaid Program. SRS's response to each recommendation begins on page 58. SRS has concurred or partially concurred with each recommendation. See indicated page numbers for additional information related to each area. See Chapter II for an overview of the Montana Medicaid program.

CHAPTER III
MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

INPUT TO MMIS

Claims Input (page 18)

Input of claims is done on a timely basis, but an inherent delay in the system was found to exist. This delay, while not necessarily effecting the operations of the Medicaid program, does slow the collection of expenditure data and therefore complicates the budgeting process.

Input of Eligible Providers (page 21)

We found no problems with the input of providers. Providers are being input in a timely and accurate manner.

Input of Eligibles (page 21)

Our review of 200 sample eligibles showed 47 discrepancies in regard to eligibility dates. Thirty-six of these discrepancies were due to a one week delay in submitting eligibility data to the MMIS system. The remaining eleven could not be explained as resulting from delays.

> Recommendation #1 (page 22)
> We recommend the department periodically reconcile their eligibility data with the MMIS.

Input of Allowable Services (page 22)

No concerns arose from our review of the fiscal agent's procedures of inputting updates of allowable services.

Input of Allowable Fees and Costs (page 22)

The fiscal agent is accurately and completely inputting allowable fees and costs.

MMIS PROCESSING (page 23)

The fiscal agent's processing procedures were found to be adequate in meeting functional objectives. The six MMIS subsystems were meeting their objectives; however, some errors were noted in MARS (management) reports. Recommendations were made to the fiscal agent concerning duplicate claims, access to the computer room, data files, production programs, and program maintenance procedures.

MMIS OUTPUT

Paid Claims Tape (page 24)

Information contained on the paid claims tape has been determined to be accurate. We found no problems with specific reports derived from the tape.

MARS Reports (page 25)

We found a number of inaccuracies in MARS reports. The causes of these problems were attributable to subsystem flaws. We were informed by SRS staff that MARS reports are seldom used.

> Recommendation #2 (page 26)
> We recommend the department address the problems encountered with the present MARS reports by identifying information and reporting needs and monitoring the subsystem to ensure future accuracy and use.

S/URS Reports (page 26)

S/URS (surveillance and utilization) reports were found to provide adequate and accurate information to meet their functional objective.

Warrant Tapes (page 26)

Based upon prior financial/compliance audits of SRS warrant outputs we conclude that warrant transactions are reasonable and the warrant tape is accurate.

OVERALL CONCLUSION ON MMIS (page 27)

Overall, the MMIS is producing complete and accurate information. Claims processing appears to be accurate and timely. There is an inherent delay within the system due to slowness in receipt of claims. The basic output produced by the system appears to be adequate with the exception of MARS reports. We noted that SRS could improve its monitoring of the MMIS.

> Recommendation #3 (page 27)
> We recommend the department take a more active role in the monitoring of the new MMIS.

CHAPTER IV
MANAGEMENT INFORMATION OFFICE (MIO)

STATISTICAL REPORTS (page 30)

Previous inconsistencies in information contained in the statistical reports were corrected in June 1984. Overall, we believe the current statistical reports are based on accurate data, that the data is being processed adequately, and that the reports present accurate Medicaid information.

RANDOM MOMENT TIME STUDY (RMTS) (page 30)

We believe the RMTS is adequate for the purpose of allocating employee time to the various federal programs. The MIO's procedures are resulting in accurate results. The system has been approved by the federal government as an acceptable allocation process.

CHAPTER V
SBAS AS A SOURCE OF MEDICAID DATA (page 32)

The Statewide Budgeting and Accounting System (SBAS), as utilized by SRS, is properly generating revenue and expenditure data. However, in its current form with established responsibility centers, it does not appear to be useful as the primary source of information to project the total Medicaid budget.

CHAPTER VI
INFORMATION USE

MEDICAID ACCRUAL (ESTIMATING TOTAL BENEFITS EXPENDITURES) (page 34)

The method used to estimate total Medicaid benefit expenditures for fiscal year 1983-84 is important because it is the basis for budget projections for fiscal years 1984-85, 1985-86, and 1986-87. The overall methodology is actually several different methodologies with their own assumptions and factors. The major portion (99 percent) of the benefits estimate is a combination of benefits estimates for:

- Aid to Families with Dependent Children (AFDC) eligibles;
- Supplemental Security Income (SSI) eligibles;
- Nursing Homes; and
- Department of Institutions Nursing Homes.

AFDC-Related Recommendation #4 (page 38)

We recommend the department:

A. Revise its estimate of fiscal year 1983-84 total expenditures for AFDC-related eligibles.

B. Continue to investigate alternate methods to estimate the dollar amount of "late claims" rather than the proportional method currently used.

SSI-Related (page 39)

The methodology appears to be providing a reasonable estimate of total expenditures at this time. In terms of accuracy the method cannot be concluded upon until all claims have been submitted. Again, an alternate method of estimating "claim lag" may be in order.

Nursing Homes Recommendation #5 (page 42)

We recommend the department refine the methodology used to estimate total nursing home expenditures by examining additional factors which are unique to late claims and by using additional data which is available.

Department of Institutions (DofI) Nursing Homes (page 42)

The method used to estimate total expenditures for DofI nursing homes is similar to the method used for other nursing homes, except SRS relies on cost data provided by DofI. We did not review the estimation procedures used by DofI. The reasonableness of the total expenditures estimate can be determined once cost data and claims are finalized for the two institutions.

Overall Methodology for Estimating Total Benefits Expenditures (page 42)

Overall, the approach used to estimate the total expenditures for fiscal year 1983-84 appears to be reasonable, but could be refined. Because of what appears to be an underestimation in the area of AFDC-related services and an overestimation for nursing homes, the accuracy of these projections may affect the overall projection. A further review of claims delay, once SRS can obtain enough historical data, appears to be necessary.

BUDGET METHODOLOGY (page 43)

The method used by the Medicaid benefits analyst to budget for Medicaid benefits for fiscal years 1984-85, 1985-86, and 1986-87 relies upon the fiscal year 1983-84 estimate previously discussed. The four major budget areas are:

- Medicaid Other (AFDC-related eligibles);
- Medicaid Other (SSI-related eligibles);
- Nursing Homes; and
- Department of Institutions Nursing Homes.

AFDC-Related Recommendation #6 (page 48)

We recommend the department:

A. Continue to examine ways to more adequately project AFDC caseload.
B. Continue to monitor service and cost data to ensure budget assumptions are remaining reasonable.
C. Reexamine the method used to establish inflation factors for cost-based providers.

SSI-Related Recommendation #7 (page 49)

We recommend the department:

A. Reexamine the "other" services area budget projection to eliminate any inaccuracies or inconsistencies.
B. Continue to monitor service and cost data to ensure budget assumptions are remaining reasonable.
C. Reexamine the methods used to establish inflation factors for cost-based providers.

Nursing Homes (page 50)

The overall formula used to estimate total nursing home expenditures appears reasonable. The factors used in the formula should be continually monitored to determine if present assumptions will change.

Department of Institutions Nursing Homes (page 51)

The overall approach used to estimate total DofI nursing home expenditures appears reasonable. We did not review DofI's methodology for determining cost per day and the total number of days for each institution. Therefore, we cannot conclude on the overall methodology.

FISCAL BUREAU (page 52)

We believe the methods used by the Fiscal Bureau for reporting costs for the state and for the federal government are reasonable.

MANAGEMENT OPERATIONS BUREAU (page 53)

Our work indicates that the procedures used by the bureau for budgeting for administrative costs are reasonable.

SRS MANAGEMENT

SRS Staffing Recommendation #8 (page 55)

We recommend the department assign staff so that there is an adequate level of review of Medicaid activity and the Medicaid budget analysis.

Information Reporting Recommendation #9 (page 57)

We recommend the department:

A. Increase its efforts to educate people outside SRS on the nature and use of Medicaid data.

B. Educate its own staff as to the need for coordination in the collection and release of Medicaid data.

CHAPTER I

INTRODUCTION

A performance audit of the Administrative Support Functions of the Medicaid program of the Department of Social and Rehabilitation Services (SRS) was requested by the Legislative Finance Committee and by SRS. The audit request was approved after a preliminary survey of the Medicaid program was presented to the Legislative Audit Committee in June 1984. This report summarizes the results of our performance audit.

OBJECTIVES OF AUDIT

The three main objectives of this audit were:

1. To determine the timeliness, accuracy, and adequacy of the collection and use of general Medicaid program data.

2. To determine how detailed data analyses are performed, what reporting procedures are used, and how information is communicated.

3. To determine if the Administrative Support Functions of the Medicaid program are being managed effectively and efficiently by SRS and to identify the causes of any inefficiencies or ineffective practices.

In addition, this report is intended to present independent information on how the Medicaid program is managed by SRS and how the program functions in Montana. We have included this aspect in our report because of the many parties who are concerned with Medicaid and because of the need to understand program terms, coverage, and funding.

SCOPE OF AUDIT

The audit focused on the Administrative Support Functions of the Medicaid program. This area is one of five areas of the Medicaid program in which audit work is feasible as identified by our June 1984 survey of the program. The four remaining areas that will be covered in later performance audits are:

1. Eligibility Policy and Field Services.
2. Administration of the Fee-Based Provider Program
3. Administration of the Cost-Based Provider Program.
4. Quality Control.

For audit purposes we defined "administrative support functions" as those involving the generation, collection, analysis, use, and communication of operating data related to the Medicaid program. These functions include:

- data processing;
- projection of program funding needs;
- budgeting and cost allocations; and
- information reporting.

The audit was conducted in accordance with generally accepted performance auditing standards. The audit did not include a review of the financial status of the department. A financial/compliance audit of the department is done by the Office of the Legislative Auditor biennially.

As part of our audit we evaluated the adequacy of the Medicaid Management Information System (MMIS). MMIS is an automated data processing system used to pay Medicaid claims and to report claims activity.

We also evaluated the operating standards used by SRS in collecting and inputting Medicaid data used for statistical purposes. We reviewed the processing of this data including the use of computer programs, statistical analysis, and compilation of output.

We reviewed SRS' methods of using and reporting Medicaid data to determine if the methods were reasonable. This included data use by SRS to project Medicaid funding needs. The time period of the data and methodology we reviewed was from fiscal year 1982-83 to the present.

REPORT ORGANIZATION

This report is presented in six chapters. The first part of the report describes the overall Medicaid program and the

allocation of the program's administrative support functions among SRS' divisions and bureaus. The next part of the report describes the inputting, processing, and reporting of Medicaid program data. The last sections discuss the use of Medicaid program data with emphasis on Medicaid budgeting. There is one appendix describing the medical services covered by Medicaid.

CHAPTER II

BACKGROUND

Medicaid is an economic assistance program designed to provide needed medical services to the poor. The program has two major goals: 1) to ensure that health care is available to those who otherwise could not afford it, and 2) to improve people's health and thus reduce their dependence on other forms of public aid.

To fully understand the Medicaid program, an understanding of its history and makeup is needed. This chapter will give an overview of the Montana Medicaid program. The chapter's objectives are threefold: 1) to provide a basis for understanding common Medicaid terms, 2) to explain how the Medicaid program operates in Montana, and 3) to illustrate changes in the Medicaid program.

THE MEDICAID PROGRAM - ITS HISTORY AND CHANGES

The Montana Medicaid program was established in 1967 as a federal-state partnership with the federal government providing financial support and basic program guidelines. SRS administers the program but must provide specific care requirements set forth by the federal government to receive matching funds.

With its inception in Montana, only basic services were offered by Medicaid: hospitalization, physicians, skilled nursing home care, prescription drugs, and dental. In 1968, optional services such as intermediate care facilities, medical equipment, and treatment by optometrists and podiatrists were included. In 1974 the Medically Needy Program was implemented. Today Montana ranks fifth of 55 states and territories in number of allowable Medicaid services.

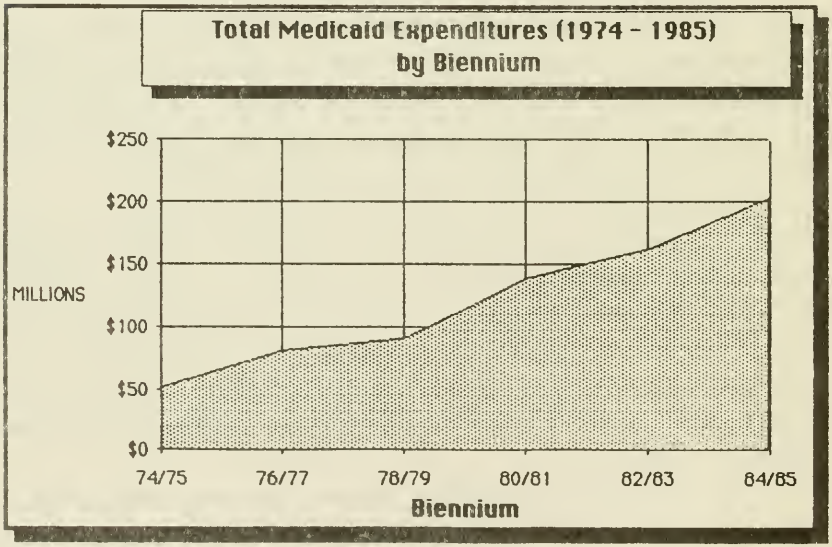
Major changes were made in national and state medical assistance programs in 1981. With the passage of the Omnibus Budget Reconciliation Act (OBRA), federal participation in Medicaid was reduced. The act provided that states be reimbursed at amounts 3 to 4.5 percent less than what they would have been allowed under

prior laws. However, an "opportunity" was given to recapture the lost federal funds to states with high unemployment, hospital rate review programs, or effective fraud and abuse recovery rates. Montana has focused its effort on increasing anti-fraud efforts.

The most recent change in federal guidelines is DEFRA - The Deficit Reduction Act of 1984. Beginning October 1, 1984, DEFRA mandated that all states increase their income limits for people to be eligible for Medicaid benefits. This act will have the effect of increasing the number of persons eligible to receive Medicaid benefits.

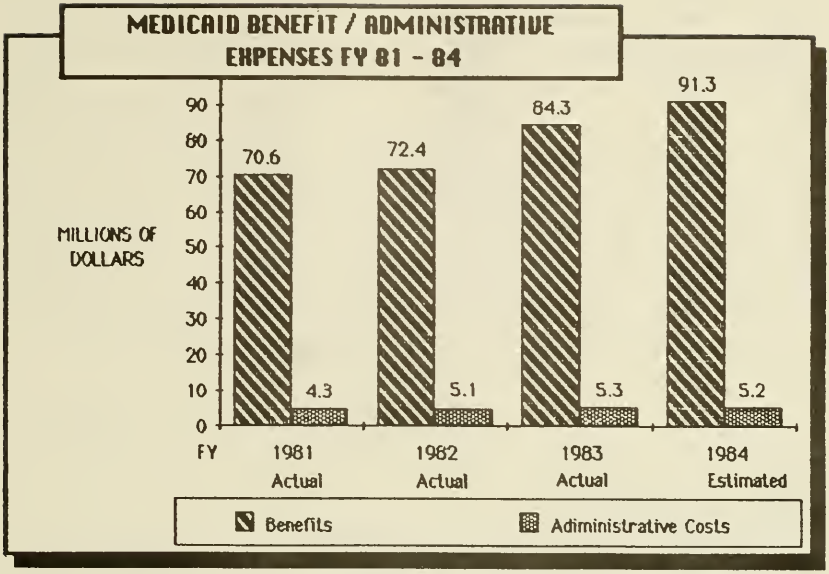
MEDICAID EXPENDITURES

Medicaid expenditures have grown dramatically. Nationally, expenditures have increased almost 200 percent from 1974 to 1984, while in Montana an increase of 300 percent has occurred over the same period. Illustrations 1 and 2 show the trend in Medicaid expenditures for Montana (includes both state and federal dollars).



Source: SRS Statistical Reports and Date of Service Reports

Illustration 1



Source: SRS Statistical Reports and SRS Fiscal Bureau

Illustration 2

Medicaid expenditures are jointly funded by federal and state governments. The rate of federal financial participation is calculated from a formula using the state's per capita income and the national average per capita income. Federal participation for benefits expenditures can vary from a minimum of 50 percent to a maximum of 83 percent. Based on the formula the federal participation rates for Montana have varied by federal fiscal year as follows:

FEDERAL PARTICIPATION RATES			
Federal Fiscal Year	Rate	Federal Fiscal Year	Rate
1970	64.23%	1979	61.10%
1971	64.23	1980	64.28
1972	67.16	1981	64.28
1973	67.16	1982	63.38
1974	66.08	1983	62.73
1975	66.08	1984	61.51
1976	63.21	1985	64.41
1977	63.21	1986	66.38
1978	61.10	1987	66.38

Source: Code of Federal Regulations and SRS records.

Illustration 3

WHO IS ELIGIBLE

Medicaid eligibility is determined largely by specific criteria established by the federal government. All recipients of cash assistance under Title IV, Aid to Families with Dependent Children (AFDC), or Title XVI, Supplemental Security Income (SSI), of the Social Security Act are eligible for Medicaid benefits. Federal law requires that all states participating in Medicaid provide services to these "Categorically Needy" people. Medicaid coverage can also be extended to the "Medically Needy." "Medically Needy" are persons who meet all but the income criteria for "Categorically Needy," yet, due to medical care expenses, their income is not sufficient to meet the costs of their health care.

The Montana Medicaid program offers coverage to both categorically and medically needy. A description of the requirements and characteristics for eligibility is given below.

Aid to Families with Dependent Children

AFDC is a cash assistance program which is jointly funded by the federal government and the state. Requirements for AFDC eligibility consist of each family having at least one child under

the age of 18 who is living with a relative and deprived of support because of the incapacity or absence of a parent. Family income and resources also cannot exceed specific standards established by federal and state guidelines. A large majority of AFDC recipients are single-parent households.

Eligibility for AFDC is determined by state Eligibility Technicians (ETs) using eligibility criteria established by federal and state standards. ETs are located in approximately 75 percent of Montana's 56 counties with the remaining counties being served by ETs from neighboring counties. Qualification for client eligibility is based on application information and personal interviews.

Supplemental Security Income Program

The SSI program is a federal cash assistance program, implemented to insure a minimum income for the aged, blind, or disabled. SSI originated in 1974, replacing separate old-age assistance, aid to the blind, and aid to the disabled programs. Each program was administered and partially financed by the states. Currently, SSI is entirely financed by the federal government.

Eligibility for SSI is determined by the Social Security Administration. SSI eligibles fall within at least one of three categories: 65 or older, blind, or disabled. To be eligible for SSI, financial resources other than income cannot exceed $1,500 for individuals or $2,500 for couples. Specific assets though are exempted: one house, an automobile with a market value less than $4,500, household and personal items up to $2,000, ordinary life insurance with a face value of less than $1,500, and an irrevocable burial trust of less than $1,500.

Medically Needy

Medically needy Medicaid coverage is an option for the states. Federal financial participation (FFP), though, is available to any state which opts to extend coverage to this category of people. Once FFP is received, the state must adhere to basic guidelines for eligibility and benefits established by the federal government.

Eligibility for the medically needy is determined by two basic conditions: (1) all non-financial eligibility criteria for AFDC or SSI must be met; and (2) incurred medical expenses must be sufficiently high so that payment in full would reduce the person's income to a level below "protected income" standards set by the state. Resource limitations also apply.

Protected income standards for medically needy recipients are determined by federal regulations. The standard for a family of one is set at the SSI benefit level, while the standard for a family of two is set at 133.3 percent of the AFDC standard for a family of two. States are given the flexibility to establish their own levels for additional family members above the family size of two. Montana allows $25 per month for each additional family member.

A "spend down" is also required of medically needy recipients. This spend down consists of reducing their income to or below a minimum level. Once at this level, Medicaid will pay for the portion of medical bills not met by the individual, or by liable third parties such as Medicare or insurance companies. Medically needy eligibles are grouped with either AFDC or SSI depending on which program's non-financial eligibility criteria were met.

Other Eligibles

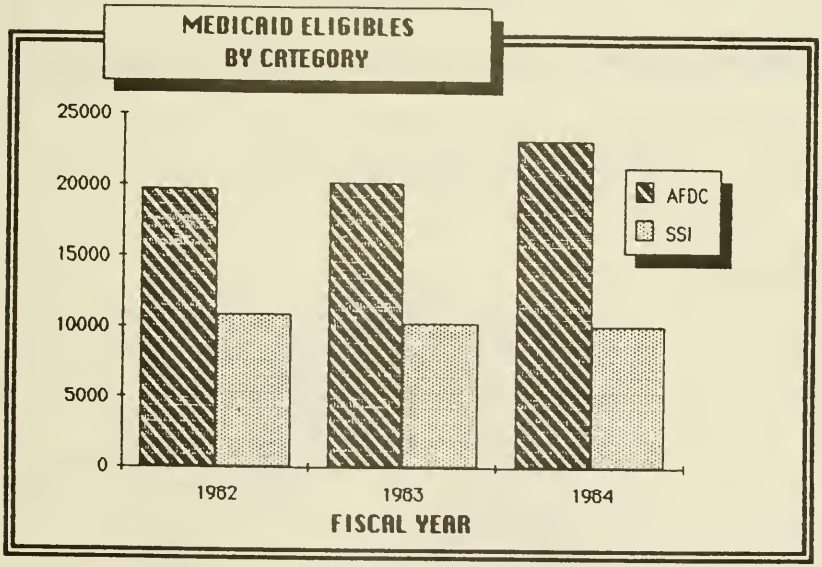
Two other groups receive additional exclusions when being determined eligible for Medicaid benefits: tribal members and refugees. Financial eligibility of Indians is determined by the same standards used for all groups; however, enrolled tribal members are allowed to exclude certain income prior to application of the standards. One example is the exclusion of payment to the tribe for use of Indian land.

Refugees in the state are eligible for medical assistance under the "Refugee Assistance" program. All recipients must be residents of Montana and have been admitted into the U.S. with permanent residence status. AFDC financial factors are used in determining the person's eligibility.

These types of eligibles are also grouped with either AFDC or SSI eligibles.

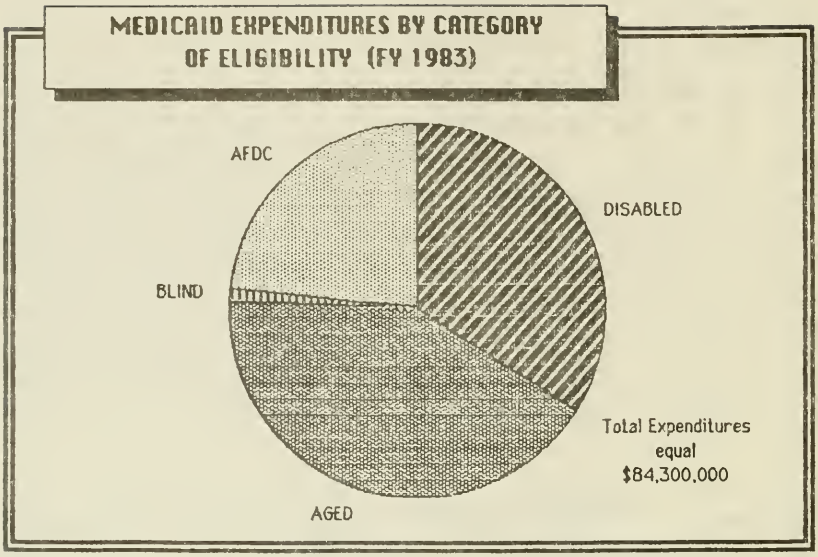
How Many are Eligible

The number of eligible persons in the state of Montana has been increasing. An eligible is any person determined to be eligible for Medicaid benefits; whereas, a recipient is a person who actually receives benefits. Illustration 4 shows that the number eligible through AFDC is approximately twice that of SSI; however, SSI recipients (aged, blind, or disabled) account for approximately three-fourths of all Medicaid expenditures (see Illustration 5). Our future audit of Medicaid Eligibility Policy and Field Services will address the topic of eligibility in more detail.



Source: SRS Date of Service Reports

Illustration 4



Source: SRS Date of Service Reports

Illustration 5

SERVICES ALLOWED

The federal government requires that all participating Medicaid states offer mandatory services to receive FFP. Montana offers all mandatory services plus 80 percent of the optional services to both categorically and medically needy eligibles.

Eight types of services are mandated by federal requirements. While the regulations require that a recipient has access to each service, the state may stipulate the amount, duration, and scope of service as long as freedom of choice is maintained.

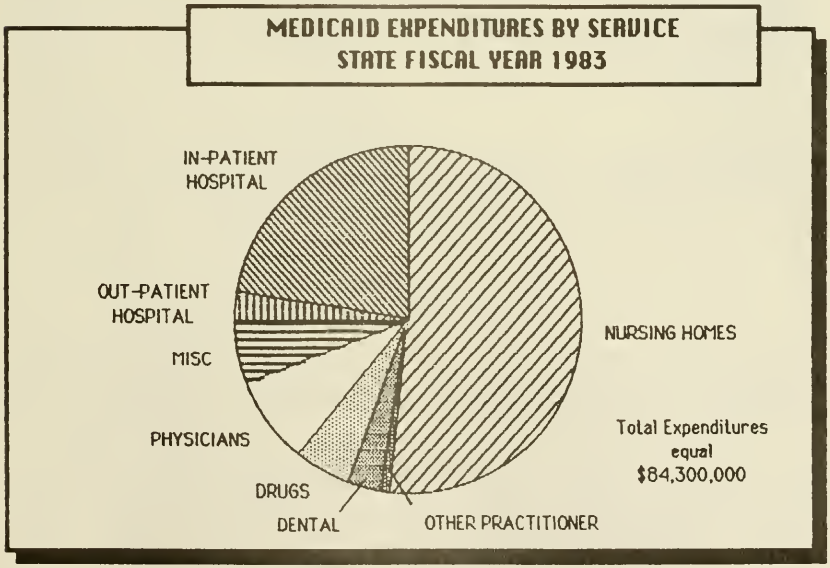
Following is a list of mandatory and optional services allowed by Montana. Appendix A details each category.

Services Allowed by Montana Medicaid		
Mandatory	Optional	
1. In-Patient Hospital	1. Dental Services	14. Private Duty Nursing Services
2. Out-Patient Hospital	2. Dentures	15. Clinic Services
3. Lab and X-Ray Services	3. Prescriptions Drugs	16. Audiology Services
4. Skilled Nursing Facilities (SNF)	4. Intermediate Care Facilities (ICF)	17. Medical Transportation
5. Family Planning Services and Supplies	5. Rehabilitative Services	18. Prosthetic Devices
6. Early and Periodic Screening, Diagnosis, and Treatment	6. Podiatrist	19. Emergency Hospital Services
7. Physican Services	7. Optometrists	20. Screening Services
8. Home Health Services	8. Eyeglasses	21. Inpatient, SNF, ICF for
	9. Physical Therapy	22. Over Age 65 and in Mental
	10. Speech Therapy	23. Institutions
	11. Occupational Therapy	24. ICF for Mentally Retarded
	12. Psychological Services	25. SNF for Under Age 21
	13. Personal Care Attendants	26. Other Practitioners

Source: Health Care Financing Administration

Illustration 6

Nursing home services account for over 50 percent of all Medicaid expenditures while hospital services make up approximately 25 percent. Illustration 7 indicates the percentage of expenditures for fiscal year 1982-83 for mandatory and optional services allowed by Montana.



Source: SRS Date of Service Reports

Illustration 7

PROVIDERS

Medical services are delivered through various in-state and out-of-state private practitioners and groups, as well as by state institutions. Approximately 4,600 providers were enrolled in the Medicaid program in fiscal year 1983-84. About 83 percent of enrolled providers participated by rendering services (see Illustration 8).

MEDICAID PROVIDERS (FISCAL YEAR 1984)

Provider Type	Number of Enrolled Providers	Number of Providers Participating
Inpatient Hospitals	295	150
Outpatient Hospitals	295	212
Physician	1,767	1,505
Optician	49	44
Optometrist	153	145
Psychologist	41	31
Podiatrist	19	19
Occupational Therapy	34	28
Physical Therapy	63	56
Speech Therapy	43	35
Pharmacy	295	281
Dentist	530	505
Nursing Home	113	100
Lab/X-ray	33	29
Other	861	652
Total	4,591	3,792

Source: MARS Report (June 1984)

Illustration 8

The "other" provider type includes ambulance services, medical equipment providers, personal care attendants, audiologists, and miscellaneous other service providers.

To become a Medicaid provider, an application is submitted by the person or group to the state's fiscal agent, a private corporation contracting with SRS to assist the state in operating the Medicaid program. The request is reviewed by the fiscal agent and verification of the provider's license is received from the

appropriate licensing board. A provider's Medicaid manual and claim forms are then sent on approval of the application.

Reimbursement for Medicaid services is made directly to the provider. Reimbursement levels are developed in accordance with state and federal guidelines. Physicians and other providers are paid a fee based on the type of service; nursing homes are paid based on a reimbursement formula for cost per day; and hospitals are paid based on their cost of operation. Medicaid providers must accept their Medicaid reimbursement as payment in full. Both fee-based and cost-based reimbursement will be addressed in future audits.

ORGANIZATION OF MONTANA MEDICAID PROGRAM ADMINISTRATION

The Montana Medicaid program is administered by the Department of Social and Rehabilitation Services (SRS). Five bureaus provide administrative support. A major function of each bureau is to furnish information to SRS personnel to assist in the development of complete and accurate Medicaid information and expenditure projections. The following is a brief description of each bureau's role as it relates to Medicaid.

- Management Operations Bureau

  Provides general program support in contract review, State Plan requirements, data processing coordination and budget monitoring.

- Data Processing Bureau

  Provides data processing and programming support to the Management Operations Bureau.

- Fiscal Bureau

  Prepares administrative cost allocations for the Medicaid program.

- Medicaid Services Bureau

  An administrative officer in this bureau serves as the "monitor" for the contract between SRS and the fiscal agent.

- Management Information Office

  Compiles and disseminates statistics pertaining to the Medicaid program.

The following illustration shows the organization of the Medicaid administrative support functions.

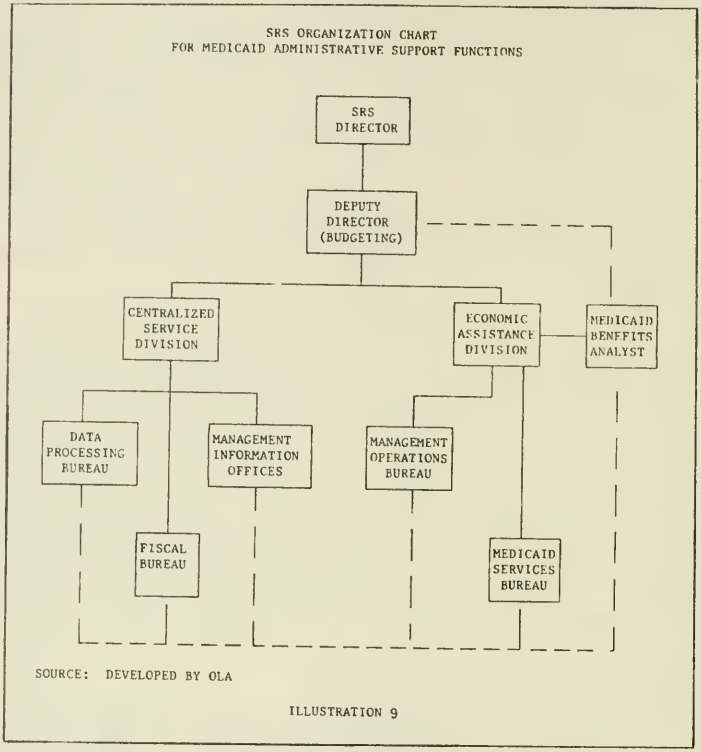


ILLUSTRATION 9

The Management Operations Bureau is responsible for projecting and monitoring administrative costs. The Fiscal Bureau provides the accounting function for the Medicaid program. Eligibility data, directly input into the MMIS for use in claims processing is supplied by the SRS Data Processing Bureau in the form of a Montana Income Maintenance System (MIMS) tape. The Management Information Office, though not directly involved in support for projections, provides overall economic assistance information.

CHAPTER III

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

The Medicaid Management Information System (MMIS) is the major source of data for the Montana Medicaid program. MMIS is an automated data processing system used to pay Medicaid claims and to report on claims activity. MMIS is administered by a private fiscal agent through a claims processing office in Great Falls, Montana, and a computer processing office in Albuquerque, New Mexico.

Because one objective of our audit was to determine the timeliness, accuracy, and adequacy of general Medicaid program data collected and used by SRS, an in-depth review of the MMIS was done. This review consisted of documenting the fiscal agent's procedures of inputting, processing, and outputting Medicaid information. The remainder of this chapter will explain our methods of review and our conclusions on each area.

THE PURPOSE OF THE MMIS

Title XIX of the Social Security Act allows states to receive 75 percent Federal Financial Participation (FFP) to pay for operation of a MMIS. This information retrieval system is determined by the U.S. Department of Health and Human Services (HHS) to provide more efficient, economical, and effective administration of the Medicaid program, thus the high rate of financial assistance. To qualify for this FFP, all states electing to use a MMIS must meet specific guidelines. Montana has had an approved MMIS since 1973.

The system handles all claims coding, data entry, reference file maintenance, and processing of edits. Claims for payment of provider services are sent to the fiscal agent in Great Falls. Claims are sorted by claim type, microfilmed, coded, and entered into the fiscal agent's main computer in Albuquerque via direct phone lines. Edits are performed during the entry phase. Claims then become either "ready for payment" or "suspended requiring further action" by the fiscal agent or by SRS.

The MMIS also allows the retrieval of provider and patient profiles. Other aspects of the Medicaid Management Information System allow the verification of provider and recipient eligibility, processing of services, checking benefit limitations, writing payment tapes, and printing reports. The main system has six subsystems that provide different functions.

The recipient subsystem maintains data on each Medicaid recipient for claims processing and reporting purposes. SRS provides a magnetic tape to the fiscal agent containing all necessary recipient data.

The provider subsystem maintains data on each provider eligible to render services covered by Medicaid. Input to this subsystem is through applications submitted by providers.

The reference file subsystem maintains information on all procedures, diagnosis codes, drugs, usual and customary fees, and system enhancement data. The subsystem contains parameters and "flags" which are used in the editing process.

The Management and Administrative Reporting Subsystem (MARS) provides support to management for review, evaluation, and decision making. Statistical reports are produced from data contained within the other subsystems.

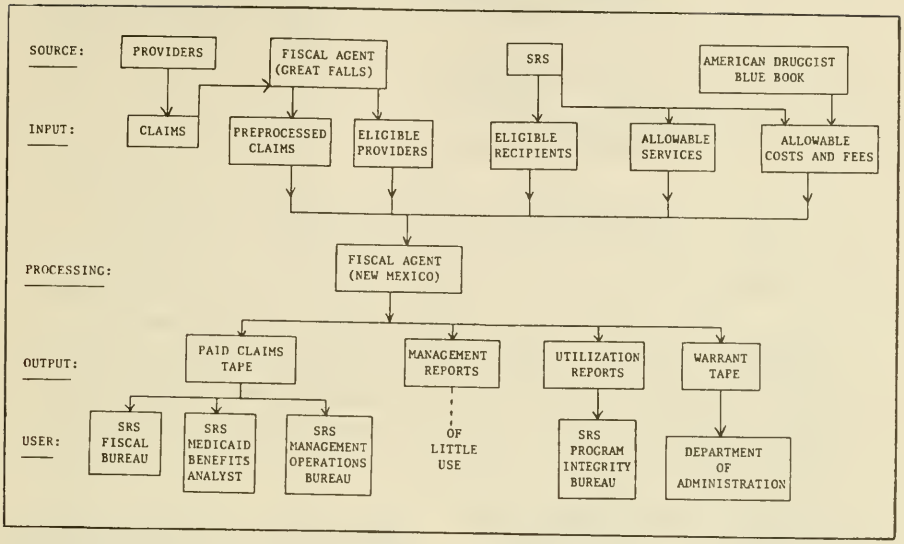
The Surveillance and Utilization Review Subsystem (S/URS) is used to maintain an appropriate on-going review of service delivery and utilization patterns.

The claims processing subsystem combines both computerized and manual processing steps. It uses other subsystems contained within the overall MMIS to receive, approve or disallow, and pay claims.

MMIS SYSTEM OVERVIEW

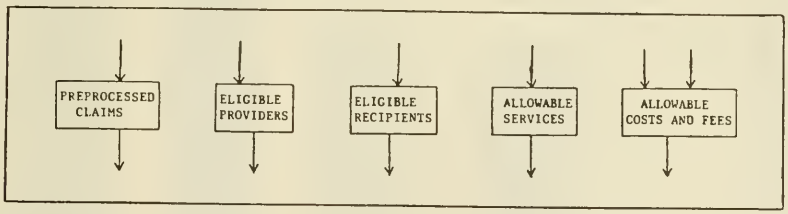
Our review of the Medicaid Management Information System consisted of analyzing three areas of the system: Input, Processing, and Output. The following chart shows the information flow through the MMIS.

MEDICAID MANAGEMENT INFORMATION SYSTEM



The following sections will detail each area in the above chart, and conclude on the adequacy of each.

INPUT TO MMIS



Claims Input

Claims are submitted to the fiscal agent in Great Falls directly by providers. The MMIS allows entry for five types of claims:

1. General Claims
   - Physician and miscellaneous providers (i.e., home health, optometrists, optician, etc.).

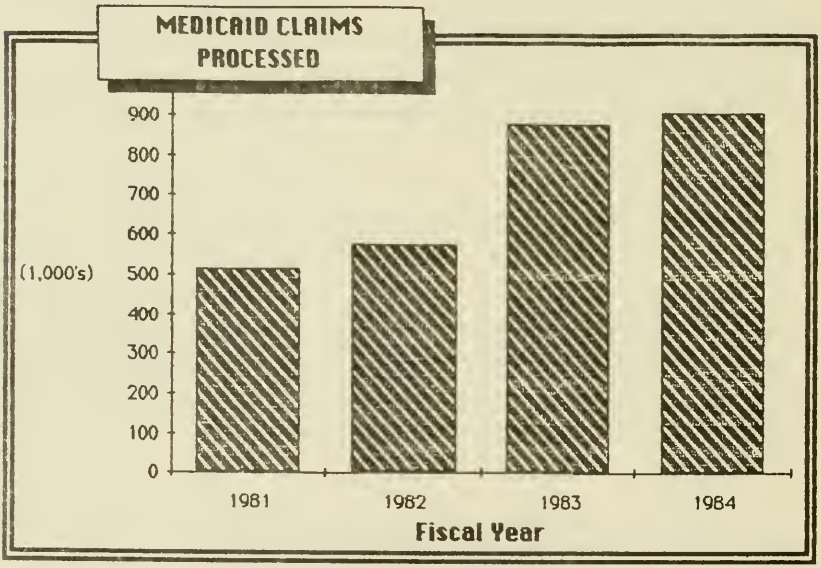
2. Hospital Claims
   - Inpatient, outpatient - all surgical procedures as paid to the individual physicians on general claims.

3. Nursing Home Claims
   - Level of care only

4. Dental Claims
   - Dental services only

5. Pharmacy Claims
   - Hospital and all other pharmacies

The number of claims submitted has been increasing in recent years. Part of the large increase in claims in 1983 was due to a change in the method used for counting drug claims. Prior to 1983 several drug purchases could be grouped into a single claim. The fiscal agent in Great Falls processed over 900,000 claims in fiscal year 1984 (see Illustration 10).

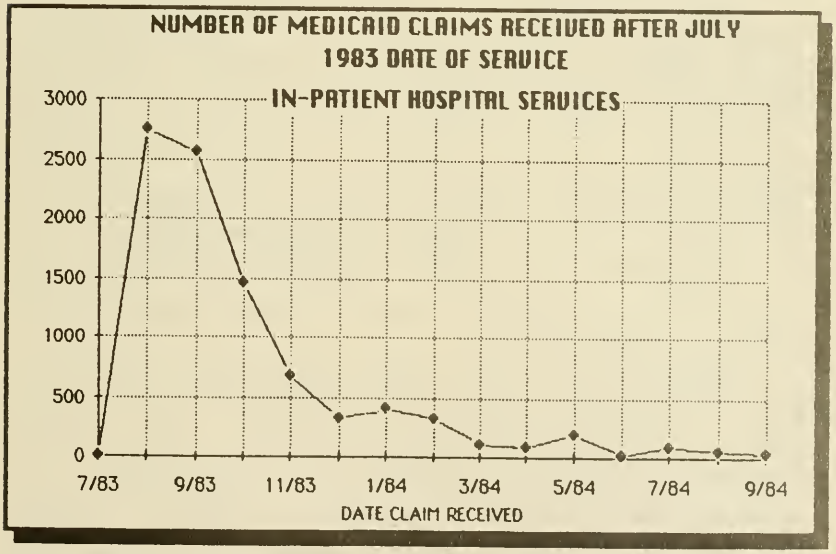


Source: MARS Reports, SRS

Illustration 10

Upon receipt, claims are scanned, sorted by type, microfilmed, and batched. Claims then go to a separate group of personnel responsible for coding and input. Once entered, claims are either paid, denied, or held pending a review. Claims held for review are sent to either SRS or to an organization contracted by SRS for claims review. When returned, they are either paid or denied, depending on the review decision.

Conclusion--From our review of the fiscal agent's inputting of claims, we found no problems with the actual input procedures. Input is done on a timely basis, but an inherent delay in the system was found to exist. Claims could be processed over a year after the date the service was provided. Causes of this delay stem from: allowing Medicaid providers 180 days to file a claim; errors on submitted claims requiring correction; and SRS' "Chase-and-Pay" efforts to recover third-party liability. The chart below gives a graphic example of the number of claims received after a July 1983 date of service, (i.e., services were provided in July 1983).



Source: SRS' Date of Service Reports

Illustration 11

This delay, while not necessarily affecting the operations of the Medicaid program, does slow the collection of expenditure data and therefore complicates the budgeting process.

Input of Eligible Providers

A provider must submit an application to become active in the Montana Medicaid program. Applications are obtained from the fiscal agent in Great Falls. Upon receipt, the fiscal agent contacts the appropriate licensing board to verify that the applicant is licensed to practice in the state of Montana. Once a provider's status is known, a provider number is given. Providers are not solicited by the state.

Conclusion--From our review of this input stage, we found no discernible problems. Providers are presently being input into the MMIS in a timely and accurate manner.

Input of Eligibles

Input of eligibles into the Medicaid Management Information System (MMIS) is provided by the Montana Income Maintenance System (MIMS), an SRS operated system. SRS sends a tape to Albuquerque on each of the first three Thursdays of every month and one tape is sent six working days before the end of the month. These tapes provide the names, I.D. numbers, and dates of eligibility (among other data) on each Medicaid eligible.

To determine the accuracy of eligibility information on Medicaid recipients, a comparison was made between the MMIS and the MIMS for a selected sample.

Conclusion--Our review of 200 sample eligibles showed forty-seven discrepancies regarding the eligibility dates of the two systems. Thirty-six of these discrepancies were due to a one-week delay in submitting the MIMS tape to the MMIS system. The remaining eleven could not be explained as resulting from delays. The cause behind these eleven discrepancies will be addressed in our separate performance audit on Eligibility Policy and Field

Services. In two instances over 40 days elapsed before the dates could be reconciled and this was after we had notified SRS of the problem. At this time, SRS performs no type of reconciliation to ensure both the MIMS and MMIS have the same data. Discrepancies are more likely to occur without periodic reconciliation to determine the causes of discrepancies. This can cause claims processing to be delayed because of the need to resolve any errors prior to payment. This slows data collection as well as delays payments to providers. SRS should periodically reconcile eligibles on MIMS and MMIS to ensure accuracy of recipient eligibility.

RECOMMENDATION #1

WE RECOMMEND THE DEPARTMENT PERFORM PERIODIC RECONCILIATIONS OF THE MONTANA INCOME MAINTENANCE SYSTEM AND THE MEDICAID MANAGEMENT INFORMATION SYSTEM.

Input of Allowable Services

Services allowed by the State are detailed in the Administrative Rules of Montana. All services were initially input into the MMIS at its inception. Any updates are entered by the fiscal agent in Great Falls upon authorization by SRS.

Conclusion--No concerns arose from our review of the fiscal agent's procedures of inputting updates.

Input of Allowable Fees and Costs

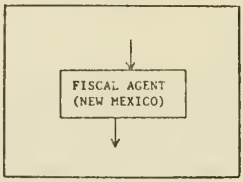
The fiscal agent is responsible for the input of all usual and customary fees allowed by Montana. Fees, both cost-based and fee-based, were originally input into the MMIS dependent on SRS and federal guidelines. As increases or decreases are given by the state, fee changes are made. No increase in fee-based services (physicians, dentists, etc.) has been authorized since June 1982. Cost-based services (hospitals, nursing homes) though,

have periodic changes made resulting from actual operating costs and changes in the reimbursement formula for nursing homes. These changes are input by the fiscal agent as they occur.

Input of drug information is performed primarily through SRS' subscription to a national drug service - the "American Druggist Blue Book Data Center." The service provides a magnetic tape to the fiscal agent in Albuquerque containing all updates on new drugs and price changes. The National Drug Code is used to identify each drug. Providers are paid on a "per dosage" basis consistent with a maximum allowable cost.

Conclusion--We found through our testing that the fiscal agent is accurately and completely inputting allowable fees and costs.

MMIS PROCESSING



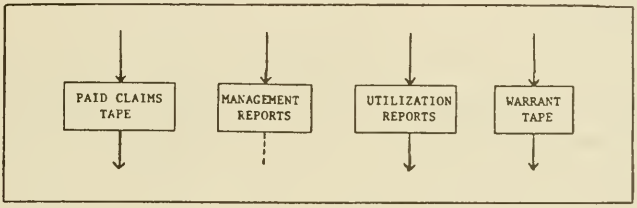
To adequately determine how the fiscal agent processes all input information, and to ensure that all output is reliable, the Office of the Legislative Auditor contracted with a private CPA firm to review the actual procedures in Albuquerque, New Mexico. The CPA firm conducted the audit in August 1984.

Key controls were identified within the MMIS and its subsystems. The CPA firm reviewed key controls to ensure that the recording, processing, and reporting of the data was properly performed by the fiscal agent.

Conclusion--The fiscal agent's processing procedures were found to be adequate in meeting functional objectives. The CPA firm concluded that we could rely on the output produced by the fiscal agent. The recipient, provider, claims, reference, MARS,

and S/URS subsystems also were found to meet their stated functional objectives; however, some errors were noted in MARS output (see page 25). Specific recommendations were made to the fiscal agent concerning duplicate claims, access to the computer room, data files, production programs, and program maintenance procedures. The CPA firm also supported our recommendation concerning SRS' need for reconciliation of MIMS and MMIS.

MMIS OUTPUT



The MMIS actually produces four categories of output: the paid claims tape, MARS reports, S/URS reports, and the warrant tape. Each has different types of data and is used for a variety of purposes. The remainder of this section details those purposes.

Paid Claims Tape

The paid claims tape is produced monthly and contains data on the activity of the Medicaid program for that time period. Information regarding expenditures and recipients by category, co-payments, claim prices, etc. is contained on this tape. In addition to this data, other reports are produced from the paid claims tape. They are the date of service reports (Medicaid Expenditures Summaries) and the monthly extract reports.

The date of service reports, as the name implies, record expenditures by their date of service. These reports are used for the purpose of projecting and monitoring benefit expenditures. Date of Service reports are produced monthly and "as needed."

The other reports produced from the paid claims tape are the monthly extracts. These reports are used by the SRS' administrative budget analyst to determine actual dollars expended each month for specific benefit programs.

Conclusion--Information contained on the paid claims tape has been determined to be accurate. We compared the date of service reports and the monthly extracts to the paid claims tape, to determine if these reports are also accurate. We found no concerns with the date of service reports and the monthly extracts.

MARS Reports

The Management and Administrative Reporting Subsystem of the MMIS has been designed to establish an information base to assist management in fiscal planning and control. The subsystem is required by the federal government to receive FFP for a MMIS. The reports are intended to help develop medical assistance policies and to monitor claims processing, recipients, and providers.

Conclusion--We reviewed internal MARS reports to determine their accuracy and subsequent use. We found a number of inaccuracies. The causes of these problems were attributable to subsystems flaws. SRS staff, when questioned to determine why these flaws were not corrected, informed us that MARS reports are seldom used; therefore, there was little need to correct problems.

The present contract with the fiscal agent expires in February 1985, at which time a new fiscal agent will be operating a MMIS. Because of this, we believe that it is not reasonable to recommend changes to the existing MMIS. We believe though, that the department should identify its reporting and information needs for the Medicaid program and subsequently include these in the new system. This would also include the monitoring of MARS reports to assure that errors do not exist.

RECOMMENDATION #2

WE RECOMMEND THE DEPARTMENT ADDRESS THE PROBLEMS ENCOUNTERED WITH THE PRESENT MARS REPORTS BY IDENTIFYING INFORMATION AND REPORTING NEEDS AND MONITORING THE SUBSYSTEM TO ENSURE FUTURE ACCURACY AND USE.

S/URS Reports

The Surveillance/Utilization Review Subsystem provides data support for the review and analysis of recipient and provider utilization patterns. The S/URS reports identify providers and recipients whose pattern of use differs from the "norm." For these cases, detailed claim data is evaluated by SRS to determine if the unusual utilization pattern is justified or if it represents fraud, abuse, or inappropriate medical care. The reports are produced quarterly and are received by the Audit and Program Compliance Division of SRS and used in their utilization analysis.

Conclusion--The subsystem was found to provide adequate information and to meet the stated functional objective; however, some inaccuracies occurred in its output after a program change by the fiscal agent. This problem was identified by SRS and corrected. The use of the reports by SRS is mainly for quality control and will be analyzed in a future performance audit.

Warrant Tapes

The MMIS produces three types of warrant output, the warrant tape itself, the Statement of Remittance (SOR) tape, and the warrant register. The warrant tape is submitted to the Department of Administration weekly with the names of providers and the amounts to be paid to each. The SOR tape details these transactions, while the warrant register produces a listing of each.

Conclusion--Based upon prior financial/compliance audits of SRS warrant outputs, we conclude that warrant transactions are reasonable and the warrant tape is accurate.

OVERALL CONCLUSION ON MMIS

The Medicaid Management Information System is the major source of information available to SRS for the purposes of administering and managing the Medicaid program. We conclude that overall, the MMIS is producing complete and accurate information.

Claims processing, the major function of the MMIS, appears to be accurate and timely. An inherent delay does exist within the total system due to the slowness in receipt of claims. This complicates other uses of MMIS data, including the budgeting process. However, the delay is not a fault of the actual MMIS.

The basic output produced by the system also appears to be adequate with the exception of the MARS reports, which were found to be inaccurate and of little use to SRS. The paid claims tape, the primary source of budgeting information, can be relied upon.

As part of our audit, we also looked at SRS' role in monitoring the overall MMIS. We noted that SRS could improve in this area. Normal monitoring requirements, such as reviewing outputs, is presently not taking place. The problems found with the MARS reports and the discrepancies between MMIS and MIMS, for example, might have been identified and corrected with better monitoring. With the expiration of the present MMIS contract in early 1985, the importance of system monitoring is increased. More complete monitoring would ensure the accuracy of output, the satisfaction of providers' needs, and the effectiveness of claims processing.

RECOMMENDATION #3

WE RECOMMEND THE DEPARTMENT TAKE A MORE ACTIVE ROLE IN THE MONITORING OF THE NEW MMIS.

CHAPTER IV

MANAGEMENT INFORMATION OFFICE

We examined the operation of the Management Information Office (MIO) of the Centralized Services Division of SRS because it is a source of Medicaid program data. Medicaid data is a large part of MIO's output, but it also compiles information on other economic assistance programs. The objective of our review was to determine the adequacy and accuracy of Medicaid information input and output by the MIO.

ROLE OF THE MANAGEMENT INFORMATION OFFICE

In relation to Medicaid, the MIO has two roles. The MIO gathers and analyzes data for the preparation of monthly and quarterly statistical reports. The MIO also designs and operates a system used for allocating costs for federal reimbursement. The MIO's manager has overall responsibility for the office and supervises a statistical technician and two half-time clerks.

Much of the Medicaid data presented in the statistical reports comes from the paid claims tape. Reports from county offices provide data on other programs such as general assistance and food stamps. The monthly statistical report is primarily used as a source of general information on public assistance. The reports are mailed to several state and federal agencies and libraries. The quarterly reports provide general information on the state's welfare programs and are often distributed at public meetings and to various groups. Both of these statistical reports are generally not used by SRS staff for making management decisions or for budgeting. This is because the information is of a general nature, and because more detailed statistics and trends are available in other department reports.

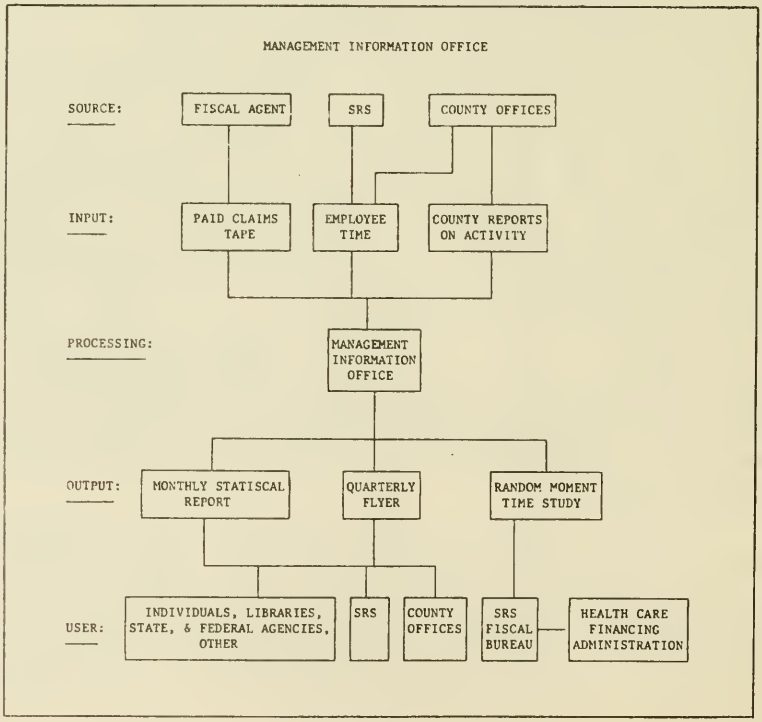
The system used for allocating costs for federal reimbursement is called the Random Moment Time Study (RMTS). Data for the RMTS comes from random telephone calls to three groups of SRS employees. Centralized Services Division and director's office staff form one group; eligibility technicians make up the second

group; and social workers make up the third group. When employees are called they are to state what program they are working on at the time. The data collected is then analyzed to determine the percent of employee time assigned to various programs. The MIO supplies quarterly reports on the RMTS to the Fiscal Bureau. The Fiscal Bureau prepares the appropriate administrative cost allocations.

The remaining sections of this chapter discuss the statistical reports and the RMTS and our conclusions on the adequacy of each.

MIO INFORMATION PROCESSING

The MIO receives information from several sources which is compiled and disseminated in other forms to various users of the information. The following chart shows the flow of Medicaid related information to the MIO and eventually to the users of MIO reports.



Statistical Reports

Our review of MIO statistical reports involved reviewing the accuracy and completeness of the data that was received, the efficiency of the processing, and the accuracy of the data contained in the reports. The extent of our review was influenced by the fact that the reports are generally used for general information on welfare and assistance rather than for management or budgeting purposes by the department.

We found that the main source of Medicaid information for the reports is the paid claims tape. In Chapter III of this report we discussed how this tape is produced and concluded that it contains accurate data. Therefore, the Medicaid portion of the statistical reports are based on accurate input.

We examined the computer programs used to generate the statistical reports and related processing procedures. The MIO appears to be processing Medicaid data completely and adequately.

Finally we evaluated the accuracy of the Medicaid data presented in actual reports produced by the MIO. During our survey we noted some inconsistencies between the statistical reports and management reports produced by the MMIS. It appears that these inconsistencies were due to duplicate counts between counties in the statistical reports. This problem was corrected as of June 1984. Our review of statistical reports after this date showed Medicaid data to be accurately reported.

Conclusion--Overall, we believe the current MIO statistical reports are based on accurate data, that the data is being processed adequately, and that the reports present accurate Medicaid information. In addition, since the reports are only used for general information purposes, as opposed to budgeting purposes, any errors would be of a relatively low risk.

Random Moment Time Study (RMTS)

Our review of the RMTS involved examining the reasonableness of the statistical model, the adequacy of the data collection procedures, and the accuracy of the output. We could not review

the actual reporting of work done by SRS employees since the contacts are made by telephone and it was not possible to observe what type of work the employees were actually doing. However, we have no reason to believe that the employees would report work activities other than what they were actually doing when they received their telephone calls.

We observed MIO staff making RMTS telephone calls and recording the information they received. We also observed the procedures for inputting this data into the state's computer. We found the data collection and inputting procedures to be adequate.

We also reviewed the theory and computer programs used to compile the inputted data. We found that these involve simple addition and ratios of employee time. The programs appear adequate for the purpose of allocating employee time among the various federal programs.

We did not review the actual allocation of personnel costs to the programs. However, our latest financial/compliance audit tested the department's cost allocation plan and concluded it reasonably satisfied the federal government's requirements.

Conclusion--Overall we believe the RMTS is adequate for the purpose of allocating employee time to the various federal programs. The MIO's procedures are resulting in accurate results. In addition, the system has been approved by the federal government as an acceptable allocation process.

CHAPTER V

SBAS AS A SOURCE OF MEDICAID DATA

The Statewide Budgeting and Accounting System is a double-entry accounting system which records and subsequently permits the reporting of assets, liabilities, fund balances, receipts and disbursements. It is also designed to be a budget control system that records budget authorizations. All levels of state government are required to use SBAS.

Based on prior financial/compliance audits we conclude that SRS is properly recording expenditures for Medical Assistance benefits and administrative costs on SBAS. SBAS records are also used by SRS to monitor total Medical Assistance expenditures and compare expenditures with appropriations.

At present, SBAS records are used to estimate Medicaid administrative costs for the Medicaid budget. Projections of Medicaid benefits are made using data compiled from the paid claims tape. The paid claims tape contains additional information that is not included on SBAS. For example, the paid claims tape contains information which can be compiled to give statistics on number of recipients, number of services provided, and average cost per service. The paid claims tape also has more recent information since SBAS is at least one month behind the paid claims tape.

As part of our review, we examined the possibility of using SBAS as the primary source of data to project the total Medicaid budget. We found that SBAS is a possible source of total budget data but only with a complete understanding of SRS' reporting procedures. In addition, other data sources would be necessary to obtain statistics for such areas as recipients, services, and cost per service. Yet another data source would be needed to evaluate the effects of delays in payments. SBAS expenditures are recorded by date of service (the same as budget projections), but because of the many accounting adjustments it would be difficult to readily use SBAS data for examining day-to-day or month-to-month activity.

In addition, the SBAS reporting center that SRS uses to record most Medicaid expenditures is titled Medical Assistance,

which does not truly represent total Medicaid expenditures. This center contains some of the Medicaid administrative costs but not all of them. For example, it does not include personal services costs for eligibility determination and assistance payments, a portion of which is assigned to Medicaid. The Medical Assistance reporting center also contains benefits expenditures that are not part of Medicaid. This includes such items as Indian Health and state medical assistance to counties.

Conclusion--SBAS, as utilized by SRS, is functioning as an accounting system. It is properly generating revenue and expenditure data. SBAS can be used to monitor expenditures against appropriations. However, in its current form with established responsibility centers it does not appear to be useful as the primary source of information to project the total Medicaid budget.

CHAPTER VI

INFORMATION USE

The previous chapters have addressed the accuracy, timeliness, and adequacy of Medicaid data produced by and for SRS. This chapter examines how that data is used by various personnel in SRS to manage the day-to-day operations of the Medicaid program and to plan for future Medicaid needs. We concentrated our audit work on the information that is provided by SRS to groups such as the Legislature, the Legislative Fiscal Analyst, the Office of Budget and Program Planning, and the federal government. The chapter is organized according to SRS personnel using and distributing the information.

MEDICAID BENEFITS ANALYST

The department designated one person to be responsible for organizing and analyzing much of the Medicaid data. A major duty of this individual was to estimate the future costs of Medicaid benefits. The analyst also monitored the monthly activity of Medicaid benefit areas (i.e., inpatient hospital, drugs, dental) and notified other SRS bureaus and management of changes that affect the Medicaid program and budget. The major source of data for the analyst is the monthly paid claims tape of Medicaid benefits. The following sections discuss the responsibilities of the benefits analyst.

Medicaid Accrual (Estimating Total Benefits Expenditures)

Because of the nature of how Medicaid benefits are paid (months of lag time before claims are received) and how expenditures are recorded (recorded on the date the service was provided), it is necessary for SRS to estimate the dollar amount of claims which will be processed after the end of the fiscal year for services which were provided during the fiscal year. This estimate is the accrual for benefits and when combined with known expenditures for the fiscal year estimates the total cost of benefits for the year.

As an example: Medicaid benefits expenditures recorded on MMIS for fiscal year 1983-84 (as accrued) are illustrated in comparison to expenditures recorded to date on MMIS for two dates: May 1984 and September 1984. Columns 2 and 3 in the following chart illustrate the effect of the lag time inherent in the Medicaid claims processing system.

FISCAL YEAR 1984 BENEFITS EXPENDITURES

Service Category	Total Expenditures[1] as Accrued (July 1984)	Total Expenditures[2] to Date (May 1984)	Total Expenditures[3] to Date (September 1984)
Inpatient Hospital	$17,506,736	$11,732,540	$17,131,161
Outpatient Hospital	2,033,117	1,514,909	1,980,961
Physician	6,753,652	4,855,147	6,497,711
Other Practitioners	1,510,807	1,210,278	1,513,294
Drugs	4,741,979	3,775,419	4,676,943
Dental	2,205,250	1,829,840	2,328,148
Other	6,862,559	4,696,063	6,568,392
Nursing Homes	39,687,038	32,120,583	38,661,584
Institutions N.H.	10,103,536	5,938,631	7,681,317
Total	$91,404,674	$67,673,410	$87,039,511

Source: 1) SRS document sent to SRS Fiscal Bureau for fiscal year-end 1984.
2) SRS May Date of Service report from Paid Claims Tape - June 13, 1984.
3) SRS September Date of Service report from Paid Claims Tape - October 10, 1984

Illustration 12

The estimate of total benefits expenditures is important when examined in comparison to spending authority. In the short term, if expenditures are estimated to exceed spending authority (appropriations), then additional appropriation authority for benefits must be received. In the long-term, the estimate of total expenditures is used to budget for future years.

Method Used to Estimate Total Expenditures for Benefits

The method used to estimate total Medicaid benefit expenditures for fiscal year 1983-84 is important because it is the basis for budget projections for fiscal years 1984-85, 1985-86, and 1986-87. The overall methodology is actually several different methodologies with their own assumptions and factors. The major portion (99 percent) of the benefits estimate is a combination of benefits estimates for:

- AFDC-related eligibles;
- SSI-related eligibles;
- Nursing Homes; and
- Department of Institutions Nursing Homes.

The following four sections present information on each methodology and conclude on their adequacy.

AFDC-Related

The method used to estimate benefits expenditures for fiscal year 1983-84 for AFDC-eligibles relies upon the following factors:

A: Fiscal year 1982-83 expenditures to date for each service area* (reported May 1984);

B: Fiscal year 1982-83 expenditures to date for each service area* (reported May 1983);

C: Fiscal year 1983-84 expenditures to date for each service area* (reported May 1984).

* The seven service areas used to summarize all Medicaid services are: 1) inpatient hospital, 2) outpatient hospital, 3) physician, 4) other practitioners, 5) drugs, 6) dental, and 7) other.

The formula used to estimate total expenditures for fiscal year 1983-84 for each service area is:

$$\text{Total} = A \times (C \div B)$$

In general terms, total expenditures for each area in fiscal year 1983-84 are estimated by taking total expenditures for fiscal year 1982-83 for that area (A) and then increasing the total again by the percentage increase in expenditures between the two years, as indicated by the ratio of ten months of reported claims in fiscal

year 1983-84 to ten months of reported claims in fiscal year 1982-83 (C ÷ B). This formula assumes:

1. The expenditures reported on May 1984 for fiscal year 1982-83 represent total expenditures for the fiscal year; and

2. The pattern of expenditures in fiscal year 1982-83 after one point in time will be the same for fiscal year 1983-84 (i.e., the percentage and type of claims processed after ten months of fiscal year 1982-83 for fiscal year 1982-83 will be the same for fiscal year 1983-84 claims processed in fiscal year 1983-84).

Conclusion--The first assumption is reasonable since the figures represented the most current information available at the time for fiscal year 1982-83. It actually represented approximately 99.5 percent of total expenditures, since all claims for fiscal year 1982-83 were still not submitted ten months after the end of the fiscal year.

The second assumption cannot be concluded upon since all claims/expenditures for fiscal year 1983-84 have not been recorded. An examination of fiscal year 1983-84 estimates versus actual recorded expenditures to date through September of 1984 will give an indication if this assumption is holding true.

ESTIMATED VS. ACTUAL EXPENDITURES (AFDC-RELATED)
FISCAL YEAR 1984

AFDC Service Area	Total Estimated	September 1984 To Date
Inpatient	$10,241,801	$10,324,897
Outpatient	1,413,937	1,392,191
Physicians	4,890,165	4,761,868
Other Practitioners	984,706	996,384
Drugs	867,479	858,025
Dental	1,662,683	1,782,342
Other	1,486,158	1,458,279
Total	$21,546,929	$21,573,986

Source: SRS accrual document and Date of Service Report

Illustration 13

From the above comparison it appears that the second assumption has underestimated total expenditures for fiscal year 1983-84. For AFDC-eligibles, there appears to be a higher percentage of claims/expenditures coming in after ten months for fiscal year 1983-84 then there was for fiscal year 1982-83. In addition, claims for services for fiscal year 1983-84 will continue to be submitted and the estimate will be further underestimated. (The estimate would have been even further understated if $125,000 of co-payments had not been collected.)

In terms of accuracy, the methodology cannot be concluded upon until all claims have been submitted. However, since total expenditures for each service area will be used to budget for fiscal years 1984-85 through 1986-87, it appears appropriate that an adjustment to the estimates that are understated be made.

An alternative method of estimating AFDC-related "claim lag" should be investigated rather than using the proportional method discussed in assumption (2) on page 37. The SRS analyst has been developing a method of estimating the number and amount of lagging claims per month by service area. This type of method could provide more information to estimate the dollar amount of "late claims." This method would also provide more current information; and if the information is monitored monthly it could help identify changes in usage patterns and claims processing.

RECOMMENDATION #4

WE RECOMMEND THE DEPARTMENT:

A. REVISE ITS ESTIMATE OF FISCAL YEAR 1983-84 TOTAL EXPENDITURES FOR AFDC-RELATED ELIGIBLES.

B. CONTINUE TO INVESTIGATE ALTERNATE METHODS TO ESTIMATE THE DOLLAR AMOUNT OF "LATE CLAIMS" RATHER THAN THE PROPORTIONAL METHOD CURRENTLY USED.

SSI-Related

The method used to estimate expenditures for the service areas for SSI is similar to the AFDC-related method shown on page 36. The total estimate for each service is:

$$TOTAL = A \times (C - B)$$

This formula assumes that assumptions (1) and (2) listed under AFDC are true.

Conclusion--The first assumption that the expenditures reported on May 1984 for fiscal year 1982-83 represent total expenditures for the fiscal year is again reasonable for the same reason it was for AFDC-related cases. The to-date expenditures represent about 99.5 percent of total expenditures for the year.

The second assumption that the pattern of expenditures in fiscal year 1982-83 after one point in time will be the same for fiscal year 1983-84 will again be examined using a comparison between estimated expenditures and to-date expenditures through September 1984 for fiscal year 1983-84.

ESTIMATED VS. ACTUAL EXPENDITURES (SSI-RELATED)
FISCAL YEAR 1984

SSI Service Area	Total Estimated	September 1984 To Date
Inpatient	$ 7,256,304	$ 6,806,264
Outpatient	617,988	588,770
Physicians	1,859,366	1,735,843
Other Practitioners	525,272	516,910
Drugs	3,873,769	3,818,918
Dental	541,166	593,777
Other	5,375,149	5,110,113
Total	$20,049,014	$19,170,595

Source: SRS accrual document and Date of Service Report

Illustration 14

From the above it appears that the same methodology used for AFDC-related cases is not underestimating the SSI-related services. It appears to be providing a reasonable estimate at this

time; however, in terms of accuracy the methodology cannot be concluded upon until all claims have been submitted. Again, another method of estimating "claim lag" rather than a proportional model may be in order.

Nursing Homes

The method used to estimate nursing home Medicaid expenditures for fiscal year 1983-84 relies upon an estimation of how many recipients will be served each month and the number of nursing home days per recipient for each month. A combination of these two estimates results in total number of days for all recipients. This number is multiplied by the net rate per day to obtain total costs.

The estimate of recipients per month is based upon actual recipients plus an estimate of recipients whose claims have not been processed yet for the fiscal year. The days per recipient are also estimated for the last two months of the fiscal year.

The estimate of rate per day is derived from a formula which includes such factors as past operating costs, occupancy rate, inflation, and geographical location. Both operating and property costs for nursing homes are taken into account. The average patient contribution per day is then subtracted from the cost per day to obtain the rate per day.

This method assumes that:

1. The lag time for claims will be similar for all months.
2. The days per recipient for May and June of 1984 will be similar to April's.

Conclusion--The assumption concerning days per recipient appears to have been reasonable. The April 1984 figure was 29.06 days, while May and June averaged 29.61. The assumption on lag time can be examined by comparing the estimate for total expenditures for fiscal year 1983-84 to those recorded to date as of September 1984.

Service Area	Total Estimated	September 1984 To Date
Nursing Home	$39,695,231	$38,661,584

The assumption appears to have overestimated total nursing home expenditures. There are still claims which will be submitted and these will reduce the $1 million difference. However, the October 1984 report reduced this amount by only $19,933. In addition, the lag time for nursing home claims is historically much less than other service areas.

We reviewed the method used to estimate claim lag and found the SRS methodology does not take into account that late claims may be of a different type than earlier submitted claims. In fact, we found that claims submitted after four months from the month of service have a tendency to reflect fewer days per month of care per recipient. Since the current methodology assumes all recipients (timely and delayed claims) receive the same number of days of care per month, it would tend to overestimate the days per recipient for delayed claims. This would overestimate the overall estimate of days used to determine the total cost.

The concept of determining the number of recipients whose claims will be delayed and then using this count to estimate future costs is a reasonable approach; however, the department should examine the approach further. Factors, such as the type of claim, the amount of claim, and the month which the services were provided, could provide additional information to refine the methodology. In addition, the current SRS estimates are based upon only two months of experience. Since the initial development of this method a number of more months data has become available and should also be used to refine the methodology.

RECOMMENDATION #5

WE RECOMMEND THE DEPARTMENT REFINE THE METHODOLOGY USED TO ESTIMATE TOTAL NURSING HOME EXPENDITURES BY EXAMINING ADDITIONAL FACTORS WHICH ARE UNIQUE TO LATE CLAIMS AND BY USING ADDITIONAL DATA WHICH IS AVAILABLE.

Department of Institutions Nursing Homes

The method used to estimate total expenditures in this area is similar to the previous method, except that SRS relies upon estimates of cost per day and total days provided by the Department of Institutions for each institution (Center for the Aged, Boulder, Galen, Warm Springs, and Eastmont). This method assumes that Department of Institution estimates are reasonable. We did not review the estimation procedures used by the Department of Institutions. Our planned audit of Medicaid in the area of cost-based providers will address the estimates provided by the Department of Institutions. Currently, the expenditures reported to date (September 1984) are $7,679,225 compared to an estimate of $10,103,536. The difference is due to the delay in submission and processing of cost reports for Boulder and Eastmont. Once the cost reports and claims from these two Intermediate Care Facilities for the Mentally Retarded are finalized, the reasonableness of the estimate can be determined.

Overall Methodology

Overall, the approach used to estimate total expenditures for fiscal year 1983-84 appears to be reasonable, but could be refined. Because of what appears to be an underestimation in the area of AFDC-related services and an overestimation for nursing homes, the accuracy of these projections may affect the overall projection. The actual effect will not be known until all claims for fiscal year 1983-84 are submitted.

The key to the methodology is to estimate the lag associated with receiving claims. A further review of claims delay, once SRS can obtain enough historical data, appears to be necessary. In addition, since SRS will change fiscal agents in March of 1985, the 1985 methodology to estimate claim lag and its accuracy may be affected by any start-up problems the new system may have.

Budget Methodology

The method used by the Medicaid benefits analyst to budget for Medicaid benefits for fiscal years 1984-85, 1985-86, and 1986-87 relies upon the fiscal year 1983-84 estimate previously discussed. The four major budget areas are:

- Medicaid Other (AFDC-related eligibles);
- Medicaid Other (SSI-related eligibles);
- Nursing Homes; and
- Department of Institutions Nursing Homes.

Each area is estimated (budgeted) separately. The following sections address the reasonableness of the budget methodology for each area.

AFDC-Related

The projection methodology used for this area is relatively straight forward for each service type:

$$\text{Total Expenditures 85} = \frac{\text{AFDC Caseload 85}}{\text{AFDC Caseload 84}} \times \text{Total Expenditures 84} \times \text{(Inflation Factor)}$$

$$\text{Total Expenditures 86} = \frac{\text{AFDC Caseload 86}}{\text{AFDC Caseload 85}} \times \text{Total Expenditures 85} \times \text{(Inflation Factor)}$$

$$\text{Total Expenditures 87} = \frac{\text{AFDC Caseload 87}}{\text{AFDC Caseload 86}} \times \text{Total Expenditures 86} \times \text{(Inflation Factor)}$$

The factors involved in the budget methodology are AFDC caseload, inflation factors, and the total expenditures for fiscal year 1983-84. The following sections will discuss each factor and

conclude on its reasonableness. For those service/provider areas that are fee-based (Physicians, Other Practitioners, Dental) the inflation factor was not included in fiscal year 1984-85 estimates since fees are frozen for this period.

AFDC Caseload -- An important factor in estimating AFDC-related expenditures is the average AFDC caseload per month.

The method used to project AFDC caseload is an equation which uses previous caseload numbers and the projected unemployment rate for Montana. The equation is:

Caseload (next month) = Caseload (this month) + Unemployment Rate (next month) X (39.068) - 285.1964 + Indian-related Caseload

This equation was used in late 1983 to project caseload. At that time SRS assumed the enrolled Indian-related caseload to remain constant at approximately 1,600. The following compares projected AFDC caseload (not including enrolled Indians) to actual for January through July 1984.

ACTUAL AND PROJECTED AFDC CASELOAD*

Date	Actual AFDC Caseload	(A) Projected Using Estimated Unemployment Rate	Difference Between Projected and Actual	(B) Projected Using Actual Unemployment Rate	Difference Between Projected and Actual
Jan 84	5,595	5,532	-63	5,635	+40
Feb 84	5,692	5,606	-86	5,737	+45
Mar 84	5,811	5,653	-158	5,835	+24
Apr 84	5,844	5,669	-175	5,890	+46
May 84	5,733	5,653	-80	5,886	+153
Jun 84	5,638	5,641	+3	5,901	+263
Jul 84	5,547	5,622	+75	5,908	+361
Average	5,694	5,625	-69	5,827	+133

*Does not include enrolled-Indian caseload.

Source: AFDC Projections November 1983, SRS Document

Illustration 15

The method used by SRS to estimate the caseload (A) has produced a reasonable average number for the period. The reasons the projections used by SRS have resulted in reasonably accurate numbers are: (1) the caseload has not made any drastic changes, (2) the actual unemployment rate was not as projected [if the estimated was close to the actual unemployment rate the estimates would have been more like column (B)], and (3) the next month's projected caseload is related to the previous month's. In light of these factors, a more accurate and adequate model may be appropriate.

There are two types of forecasting models: time series and regression (causal) models. In the first type, prediction of the future is based on past values of the variable or past errors. These time-series methods discover the pattern in historical data and extrapolate that pattern into the future. Causal models assume the factor to be forecasted exhibits a cause-effect relationship with one or more independent factors. The regression model discovers the form of the relationship and uses it to forecast future values. In general, time series are used more easily to forecast, where regression can be used with greater success to determine how a policy decision affecting one factor would affect the independent factor.

From SRS attempts at formulating a model to predict AFDC caseload it is evident that they were looking for a cause-effect relationship. The analyst is using the unemployment rate as the factor to predict caseload. Our analysis indicates that using the unemployment rate or the change in the rate as the sole factor is not adequate. The rate, itself, is merely a ratio of unemployed to employable (those employed and those unemployed); therefore, the actual number of unemployed can vary even though the rate remains the same. For example: a 9.9 percent unemployment rate in March 1983 represented 41,299 unemployed, while in December of 1983 the same rate represented 38,686 unemployed. The actual number of unemployed had decreased in 9 months. In the same period the AFDC caseload increased from 5,418 to 5,692. Unemployment may be one factor affecting caseload, but from our analysis it

does not exclusively explain changes in AFDC caseload, and other factors (or combination of factors) should be examined to develop an adequate model.

SRS' use of previous caseloads to predict future caseloads is more closely related to time-series forecasting than to a cause-effect model. In fact, we developed a formula, just using prior caseload numbers and without using the unemployment rate, that predicted the average caseload for the period in Illustration 13 to within nine cases. Our formula is by no means intended to be a model for predicting caseload, but it is an indication that a time-series forecasting model just using prior caseload numbers may be more accurate and more adequate for projecting AFDC caseload, if SRS is not concerned with a cause-effect relationship. A time-series model may also be appropriate because SRS historical data on caseload appears to indicate a seasonal pattern: caseloads dropping in May and June of each year, and then increasing in other months.

In July of 1984 the assumption of the enrolled-Indian caseload remaining constant at 1,600 was changed based upon an observed increase over six months. The caseload went from 1,596 in January to 1,728 in July. Despite a constant increase in this caseload, the assumption was made during the budgeting process that it would remain constant at 1,728 for the next three fiscal years. The only factor that SRS used to explain the caseload increase was the unemployment rate and it was found not to be correlated. To assume that the average caseload is once again going to remain constant may not be reasonable. An examination of the type of enrolled-Indian case (i.e., how long individuals remain on the caseload, how many family members per case, type of new eligible) may be appropriate if SRS is to find a factor or factors which explain changes in caseload.

Inflation Factors -- For fiscal year 1984-85 the inflation factor of 8 percent was used to estimate cost increases for inpatient hospital, outpatient hospital, drugs, and other care. The choice of 8 percent was based upon an estimate supplied by the Legislative Fiscal Analyst, the Montana Hospital Association, and price

indexes for consumer goods. The methodology of estimating the 8 percent rate appears reasonable.

For fiscal years 1985-86 and 1986-87 a 4 percent inflation factor has been applied to all service areas. Since SRS can set rates for fee-based providers, the 4 percent increase can merely be applied to the current rate and the budget will reflect actual increases. However, for certain services mentioned in the preceding paragraph, many costs are affected by factors beyond SRS' control. The method used to establish the 4 percent inflation factor for these areas does not appear appropriate. The method was based upon input from public meetings. An original figure of 6.2 percent was established using economic predictions for inflation. This rate was reduced for reasons not based upon economic forecasting, but on a policy decision. If cost-based providers voluntarily limit their increases to under 4 percent, the 4 percent figure is reasonable; however, as a budgeting methodology with no control over what cost-based providers will charge, it appears to be inadequate and may underestimate expenditures in the largest area of service - inpatient hospital.

Total Expenditures for Fiscal Year 1983-84 -- Basing next year's expenditures on this year's expenditures is a common budgeting method and is a reasonable way of estimating. SRS, however, has to rely upon an estimate of fiscal year 1983-84 expenditures. The most complete information available on expenditures is for fiscal year 1982-83. Therefore, SRS is using the most current complete information available (fiscal 1982-83) to predict fiscal year 1983-84 expenditures. The accuracy of this estimate will affect the budget for future years (see Recommendation #4), and the accuracy of this figure will not be totally known until all claims have been processed for that fiscal year.

Conclusion--The projection methodology relies upon two factors to account for increases in yearly benefit expenditures: inflation and AFDC caseload. It assumes recipients as a percent of caseload will remain constant and number of services per recipient will also stay constant. These two assumptions have held true for the last two years, but should be monitored to determine if changes are occurring.

The fact that the methodology takes into account inflation and increase in caseload makes the method reasonable. However, SRS should continue to examine ways to more adequately project AFDC caseload and review the manner in which inflation factors are established and used in the budget process. In addition, SRS should continue to monitor service and cost data to ensure that assumptions made in budgeting are remaining reasonable.

RECOMMENDATION #6

WE RECOMMEND THE DEPARTMENT:

A. CONTINUE TO EXAMINE WAYS TO MORE ADEQUATELY PROJECT AFDC CASELOAD.

B. CONTINUE TO MONITOR SERVICE AND COST DATA TO ENSURE BUDGET ASSUMPTIONS ARE REMAINING REASONABLE.

C. REEXAMINE THE METHOD USED TO ESTABLISH INFLATION FACTORS FOR COST-BASED PROVIDERS.

SSI-Related

The projection methodology used for this area is similar to the AFDC-related method except caseload is not a factor. For each service type the methodology is:

Total Expenditures 85 = (Total Expenditures 84) X (Inflation Factor)

Total Expenditures 86 = (Total Expenditures 85) X (Inflation Factor)

Total Expenditures 87 = (Total Expenditures 86) X (Inflation Factor)

The factors involved in the budget methodology are inflation and estimated total expenditures for each service type for fiscal year 1983-84. For those services/providers areas that are fee-based (Physicians, Other Practitioners, Dental, and Other Care), the inflation factor was not included in fiscal year 1984-85 estimates since fees are frozen for the period.

Inflation Factors -- The discussion of inflation factors for AFDC-related services applies for SSI-related services also. The

only difference is that the inflation factor was not applied to the "other" care service area as it was for the same service area under AFDC-related eligibles. This is inconsistent and appears to be an oversight rather than a change in methodology.

Total Benefit Expenditures for Fiscal Year 1983-84 -- Again, SRS is relying upon an estimate of fiscal year 1983-84 expenditures for each service type. The accuracy of this estimate will not be known until all claims have been processed for the fiscal year.

Conclusion--The projection methodology relies upon one factor to account for increases in benefits expenditures between years; and that is the inflation factor. The methodology assumes that the average number of recipients per year will remain constant and the average number of services per recipient per year will also be constant. There is not enough historical data to either support or refute these assumptions. The number of recipients and number of services per month for fiscal year 1983-84 have remained relatively constant which would indicate that the assumptions are reasonable at this time. These factors should be continually monitored to determine if the assumption will change with changes in such other factors as the number of SSI eligibles or number of providers.

RECOMMENDATION #7

WE RECOMMEND THE DEPARTMENT:

A. REEXAMINE THE "OTHER" SERVICE AREA BUDGET PROJECTION TO ELIMINATE ANY INACCURACIES OR INCONSISTENCIES.

B. CONTINUE TO MONITOR SERVICE AND COST DATA TO ENSURE BUDGET ASSUMPTIONS ARE REMAINING REASONABLE.

C. REEXAMINE THE METHODS USED TO ESTABLISH INFLATION FACTORS FOR COST-BASED PROVIDERS.

Nursing Homes

The methodology used to provide budget estimates for nursing homes is based upon the following formula:

Total Cost = [(Cost Per Day) - (Patient Contribution)]
X (Residents) X (Days Per Resident)

SRS must estimate cost per day, patient contribution, number of Medicaid residents and days per month per resident.

Cost Per Day -- The total cost per day is derived from the SRS date of service report. The estimate of the base amount for fiscal years 1984-85 through 1986-87 was calculated from the first two months of fiscal year 1984-85. Using these months to estimate the yearly cost appears to be reasonable since in the past the monthly cost per day figures remain relatively constant throughout the fiscal year with increases in costs coming with determinations of new nursing home costs at fiscal year-end. For example, the cost per day increased between June and July of 1984, by approximately $2.50 per day. This represents about an 8 percent increase. For fiscal years 1985-86 and 1986-87 the factor used to inflate costs by SRS is 4 percent. This factor appears reasonable since SRS can increase the nursing home rate by 4 percent and the budget will reflect actual increases. The 4 percent factor was based on a legal settlement between SRS and the state's nursing homes.

Patient Contribution -- The patients' contribution for fiscal year 1983-84 to nursing home care per day is also derived from the SRS date of service report. This amount is adjusted for fiscal years 1984-85 through 1986-87 by increasing for inflation. For 1984-85 the inflation factor was obtained from economic forecast reports which appeared reasonable. The 1985-86 and 1986-87 factors do not appear reasonable since the rate was based on a policy decision rather than upon economic forecasting.

Resident -- The estimate of number of residents is calculated from the date of service reports. The number of residents per month is recorded and a yearly monthly average is calculated.

This number is assumed to stay constant into fiscal year 1984-85. The assumption is reasonable at this time since figures from the last two years show a relatively consistent month to month resident population. The budget estimates for fiscal years 1985-86 and 1986-87 project an increase in total licensed nursing home beds in the state. The estimate of Medicaid residents is increased proportionally, which is a reasonable assumption.

Days per Resident Per Month -- The methodology to calculate days per month is to average the days per resident for each resident and then average the monthly figures. The actual numbers come from the date of service report. The average also has remained relatively constant over the last two years and the budget estimates assume that it will continue to remain stable. This appears to be a reasonable assumption.

Conclusion--The overall formula used to estimate total nursing home expenditures appears reasonable. The factors used in the formula: cost per day, patient contributions, inflation factors, number of residents and days per resident per month should be continually monitored to determine if present assumptions will change. Number of available beds and the effect of caring for the elderly at home rather than in nursing homes are two factors that may significantly affect the methodologies assumptions in the near future.

Department of Institutions Nursing Homes

The methodology used to estimate the Medicaid nursing home benefits budget for the Center for the Aged, Boulder River School and Hospital, Galen, Warm Springs, and Eastmont is similar to the general nursing home projection.

Total Cost for Each = (Cost Per Day) X (Total Days Per Year)

Cost Per Day -- The cost per day is derived from Department of Institutions (Dofl) figures. The base amount for fiscal year 1984-85, which comes from Dofl, is used for fiscal years 1985-86 and 1986-87. As for other nursing homes, this base amount is

inflated by 4 percent for both years by SRS. However, since we did not review Department of Institutions' methodology we cannot conclude on the accuracy of the methodology.

Total Days Per Year -- The total number of days for each institution is supplied by the Department of Institutions. We did not evaluate the department's estimate of total days. In preparing the budget, SRS assumes that the number of days will remain constant for all institutional units for three fiscal years (1984-85 through 1986-87). For fiscal years 1982-83 and 1983-84 the total number of days for institutional nursing home care remained relatively constant: 152,909 days for fiscal year 1982-83 and 152,361 days for fiscal year 1983-84. Unless changes in institutional policy or population occur, it appears that a constant number of days is a reasonable assumption.

Conclusion--Since we did not review the methodology used by the Department of Institutions, we cannot conclude on the overall adequacy or accuracy of the methodology. The approach appears reasonable to estimate total Medicaid costs for the institutions.

FISCAL BUREAU

The Fiscal Bureau's role in the Medicaid program is one of support. It serves an accounting function, providing revenue figures and expenditure figures to both SBAS and federal reports. The bureau is also responsible for the Cost Allocation Plan. This plan allocates indirect costs to specific responsibility centers so the state can receive the appropriate federal reimbursement for each program.

The Fiscal Bureau reports Medicaid expenditures on SBAS by date of service. In Chapter V we concluded that SBAS correctly reports revenue and expenditures. We did not do any further testing of SRS' SBAS records. The Fiscal Bureau completes necessary federal reports on Medicaid expenditures. We were able to reconcile the federal reports to SBAS. Therefore, it appears that the federal reports are also accurate. The Cost Allocation Plan is based on information from the Random Moment Time Study. In Chapter IV we concluded that the RMTS produces accurate

data. In addition, our latest financial/compliance audit concluded the plan reasonably satisfied the federal government's requirements.

Conclusion--Overall, we believe the methods used by the Fiscal Bureau for reporting costs for the state and for the federal government are reasonable.

MANAGEMENT OPERATIONS BUREAU

The Management Operations Bureau (MOB) is operated as part of the Economic Assistance Division of SRS. Its purpose is to provide management support in many areas, including the development of the division's biennial budget and monitoring expenditures, for both benefits and administrative costs. Medicaid is only one of the economic assistance programs MOB is responsible for.

Budgeting for a major portion of Medicaid administrative costs is the responsibility of the MOB administrative costs analyst. The remainder of the Medicaid administrative costs are handled by the Fiscal Bureau through the Cost Allocation Plan. Salaries, equipment, travel, rentals, contracted services, and maintenance costs, among others, are Medicaid administrative costs. The analyst adjusts all costs except contracted services, based on historical expenditures. Contracted services are based on anticipated needs while any outstanding costs are accrued at year-end. Once the program's components have been budgeted for, the information is sent to Fiscal Bureau for input into SBAS and various federal reports.

Conclusion--Our analysis of this area consisted of only reviewing the process of budgeting for administrative costs. We did not analyze actual cost figures; however, our most recent financial compliance audit tested actual dollar amounts and concluded that each was reasonable. Our work indicates that the procedures used by MOB for budgeting for administrative costs are reasonable.

SRS MANAGEMENT

Another user of Medicaid program data is SRS management. SRS management includes the Department Director, the Deputy

Director, and the Administrator of the Economic Assistance Division. SRS management does not generally use or rely on Medicaid data in the basic form that is received by other staff members. Rather, management receives reports and information based on data that has already been compiled, condensed, and interpreted by other staff members.

SRS management is responsible for the overall organization, planning and directing of the Medicaid program. Management establishes policies and delegates specific functions to various staff members. Management is responsible for compiling and submitting reports and budgets to the Governor and the Legislature. Since Medicaid is only one of SRS's programs, SRS management is working with several welfare programs rather than just the Medicaid program.

Our review has identified two areas where SRS management could improve its administrative procedures. The first is the organization of staffing for the Medicaid program. The second is the reporting of Medicaid information to groups outside of SRS.

SRS Staffing

Presently one person, the Medicaid benefits analyst, is responsible for the area of Medicaid benefits. This person calculates the Medicaid benefits accrual at the end of each fiscal year and calculates the biennial Medicaid benefits budget prior to each legislative session. In addition, this person monitors program expenditures looking for trends and potential problems such as budget short falls. The information he interprets and compiles is reported to SRS management.

With one person responsible for this complex and important area it is possible that SRS management is "putting too many eggs in one basket." Since the Medicaid benefits analyst reports to the Economic Assistance Division administrator there is no other person available to share the responsibilities and duties. Therefore, with the present organizational/reporting structure there can only be superficial review of the analyst's work which includes budgeting

methodologies and actual budget figures. Our work in reviewing the budget process showed that it is an area that is not easily understood without indepth analysis.

Another aspect of having only one person involved with the details of the budget process is that there is insufficient backup if that person leaves his present position. SRS had to deal with this situation when the Medicaid benefits analyst resigned toward the end of our audit work. This occurred at a critical time in the budget process because of the close proximity to the legislative session.

We believe SRS management should assign staff so that there is an adequate level of review of Medicaid activity and the budget process. This would allow a more thorough understanding of budget methodologies, increased documentation and less reliance on one person's knowledge of the budget.

RECOMMENDATION #8

WE RECOMMEND THE DEPARTMENT ASSIGN STAFF SO THAT THERE IS AN ADEQUATE LEVEL OF REVIEW OF MEDICAID ACTIVITY AND THE MEDICAID BUDGET ANALYSIS.

Information Reporting

We believe SRS management could improve its reporting of information to groups outside SRS. During our survey we noted inconsistencies in Medicaid program data that was reported to the Legislative Finance Committee. One reason this occurred is because of the nature and timing of Medicaid data. There are terms that are not always easy to understand and SRS generates different reports for different purposes. For example, it is important to distinguish between people who are eligible for Medicaid (eligibles) from people who have actually received Medicaid services (recipients). Some SRS management reports report expenditures by date of payment while others report by date of service. In addition, because of the time lag in receiving and paying Medicaid claims, more exact data on expenditures becomes available each month.

Therefore, budget projections made with data available in September may not be the same as projections made with data available in January.

Another reason inconsistent data can be released is because there are several sources of Medicaid data within SRS. The Management Information Office releases periodic statistical reports containing Medicaid data, while the Economic Assistance Division responds to requests for information from legislative committees.

The department could address these inconsistencies through education of those involved in compiling and using the data. SRS management could better educate people outside SRS. This would include the Legislature and the executive and legislative budget analysts. Our audit work indicated that in the past there was insufficient communication between SRS and these other groups. Because of the nature and size of the Medicaid program, it is necessary for individuals to make a commitment of time and energy to learn about the program. Since these groups outside of SRS have many other priorities they have a limited amount of time and energy available to spend on Medicaid. It is necessary, therefore, for SRS to make the learning process as easy as possible. For example, all parties who deal with the Medicaid budget should first understand the changing nature of Medicaid data and then agree on information needs. Documentation of the budget methodology is also essential. The documentation can be used by those reviewing the budget and it will also provide a basis for SRS personnel to develop future budgets.

Because of the diversity and complexity of Medicaid data, we believe SRS management should make an effort to coordinate the data within its own department. SRS should identify all information sources within the department and educate its own staff as to the need for coordination. Once SRS personnel coordinate their efforts, the inconsistencies can be addressed.

RECOMMENDATION #9

WE RECOMMEND THE DEPARTMENT:

A. INCREASE ITS EFFORTS TO EDUCATE PEOPLE OUTSIDE SRS ON THE NATURE AND USE OF MEDICAID DATA.

B. EDUCATE ITS OWN STAFF AS TO THE NEED FOR COORDINATION IN THE COLLECTION AND RELEASE OF MEDICAID DATA.

AGENCY RESPONSE

DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES

TED SCHWINDEN GOVERNOR

P.O. BOX 4210

STATE OF MONTANA

HELENA, MONTANA 59604

November 26, 1984

RECEIVED
NOV 26 1984
MONTANA LEGISLATIVE AUDITOR

Scott A. Seacat, Deputy Legislative Auditor
Office of the Legislative Auditor
State Capitol
Helena, MT 59620

Dear Scott:

Attached is the Department of Social and Rehabilitation Services Response to your Performance Audit of the Medicaid Administrative Support Function. I would like to take this opportunity to thank you and your staff for what I consider an outstanding job of evaluating the Medicaid Administrative Functions. Your report was very through, informative and well written. It is a document which clearly addresses the complexities of the Montana Medicaid Program in a understandable fashion. You and your staff can be proud of a job well done.

If further information is required, please contact me directly.

Sincerely,

John D. LaFaver
Director

JDE/064

Attachment

Recommendation #1:

We recommend the department periodically reconcile their eligibility data with the MMIS.

Agency Response:

Concur. The department recognizes the need to reconcile its eligibility data. This need has been addressed in the implementation of the new MMIS which will become operational on March 1, 1985. Reconciliation will be performed on a quarterly basis.

Recommendation #2:

We recommend the department address the problems encountered with the present MARS reports by identifying information and reporting needs and monitoring the subsystem to ensure future accuracy and use.

Agency Response:

Concur. The inaccuracies identified will be rectified with the implementation of the new MMIS. Considerable effort has already been expended to insure the detailed design specifications for the new MMIS address the deficiencies found, thus enhancing department use of the MARS reports.

Recommendation #3:

We recommend the department take a more active role in the monitoring of the new MMIS.

Agency Response:

Concur. The department recognizes the importance of contract monitoring to ensure efficient operation of the MMIS and, as a result, has recently contracted with a data processing professional to function as the project leader for the new system's implementation. Following implementation the department will continue its high level involvement with the new contractor.

Recommendation #4:

We recommend the department:

a. Revise its estimate of fiscal year 1983-84 total expenditures for AFDC-related eligibles.

b. Continue to investigate alternate methods to estimate the dollar amount of "late claims" rather than the proportional method currently used.

Recommendation #5:

We recommend the department refine the methodology used to estimate total nursing home expenditures by examining additional factors which are unique to late claims and by using additional data which is available.

Agency Response #4 and #5:

Concur. The department will revise its Fiscal 1984 Medicaid accrual to reflect the level of expenditures now expected. The department will also update its budget projections for the 1987 biennium and will present these revisions to the appropriations subcommittee early next session.

The department will continue to improve its forecasting methodologies and will make special efforts to utilize alternative approaches where appropriate.

Recommendation #6:

We recommend the department:

a. Continue to examine ways to more adequately project AFDC caseload.

b. Continue to monitor service and cost data to ensure budget assumptions are remaining reasonable.

c. Reexamine the method used to establish inflation factors for cost-based providers.

Recommendation #7:

We recommend the department:

a. Reexamine the "other" services area budget projection to eliminate any inaccuracies or inconsistencies.

b. Continue to monitor service and cost data to ensure budget assumptions are remaining reasonable.

c. Reexamine the methods used to establish inflation factors for cost-based providers.

Agency Response #6 and #7:

Partially concur. The department will continue its commitment to improve its budget methodologies and its program monitoring activities.

Our estimate of cost increases necessary to continue current level services assumes that the department's plan for hospital cost containment is adopted. This plan would change hospital reimbursement from a cost-based structure to a prospective payment system utilizing a type of diagnostic related groupings to determine specific reimbursements.

Recommendation #8:

We recommend the department assign staff so that there is an adequate level of review of Medicaid activity and the Medicaid budget analysis.

Agency Response:

Concur. Staff assignments have been realigned within limited resources to provide backup for this critical function.

Recommendation #9:

We recommend the department:

A. Increase its efforts to educate people outside SRS on the nature and use of Medicaid data.

B. Educate its own staff as to the need for coordination in the collection and release of Medicaid data.

Agency Response:

Concur. The department has, over the past six months, made an extensive effort to educate individuals about the Medicaid Program. Formal presentations have been made to the Legislative Finance Committee, Fiscal Analyst staff, Legislative Audit staff, and Budget office staff.

JDE/061

APPENDIX

APPENDIX A

MEDICAID SERVICES

Listed below are the eight mandatory Medicaid services and the 26 optional services provided by SRS. Also listed are the limits on each service as applied by SRS and recipient co-payments.

Mandatory Services

1. Inpatient Hospital

   - Must be medically necessary.
   - Drug and alcohol detoxification limited to 4 days unless a concomitant condition requires hospital care.
   - Sterilizations and abortions limited by federal regulations.
   - Experimental services (e.g., liver transplants) are not covered.
   - Recipients co-pay $3.00 per day up to $66 per admission.

2. Outpatient Hospital

   - Limited to emergency room services and services covered by Medicaid in a non-hospital setting and ordered by or under the direction of a physician. Emergency care and lab or X-Ray on an outpatient basis are mandatory. Occupational therapy, physical therapy, and some other services provided by hospitals on an outpatient basis are optional.
   - Experimental services are not covered.
   - Recipients co-pay of $1.00 per service.

3. Laboratory and X-ray Services

   - Ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice, or ordered and billed by a physician but provided by an independent laboratory.
   - Experimental services are not covered.
   - Recipients co-pay of $1.00 per service.

4. Skilled Nursing Facilities (SNF)

   - Ordered by a physician.

   - Certified by SRS for level of care prior to admission/and payment, and recertified every six months through utilization review.

5. Family Planning Services and Supplies

   - Sterilization and abortion must meet federal regulations, which will allow payment of abortions only if the life of the mother is in danger.

6. Early and Periodic Screening, Diagnosis, and Treatment

   - Experimental services are not covered.

   - Limited to individuals under 18 years of age. (EPSDT is required to be made available to all eligible children under 21 years of age. But, at the state's option, children over 18 are not eligible for AFDC as a dependent child.)

7. Physician Services

   - Sterilizations/abortions limited by federal regulations.

   - Experimental services are not covered.

   - Cosmetic services are not covered unless severe impairment to patient's psycho-social well-being is demonstrated and treatment has prior authorization.

   - Recipients co-pay of $1.00 per service.

8. Home Health Services

   - Ordered by a physician.

   - Must be medically necessary.

   - Limited to 200 visits per year.

   - Capped at $400 per month unless prior authorization.

   - Equipment and supplies costing more than $75 require prior authorization.

   - Experimental services are not covered.

   - Recipients co-pay of $1.00 per service.

Optional Services

1. Dental Services and 2. Dentures

- Extensive dental services must have prior authorization. (Extensive refers to crowns, bridges, dentures either partial or full, root canals and all orthodonture.)
- Experimental services are not covered.
- Recipients co-pay of $1.00 per service.

3. Prescription Drugs

- Prescribed by physician.
- Less-than-effective and experimental drugs are not covered.
- Recipients co-pay of $.50 per prescription.

4. Intermediate Care Facilities (ICF)

- Ordered by a physician.
- Certified by department for level of care prior to admission/and payment, and recertified through utilization review every six months.

5. Rehabilitative Services (Durable Medical Equipment and Supplies)

- Purchase of items which occur only rarely must be prior authorized.
- Rental charges may not exceed purchase price.
- Ordered by a physician.
- Experimental devices are not covered.
- Recipients co-pay of $1.00 per service.

6. Podiatrists

- Experimental services are not covered.
- Recipients co-pay of $1.00 per service.

7. Optometrists and 8. Eyeglasses

- Eye examination limited to 1 annually.
- 1 pair of eyeglasses annually for individuals under 21. Reimbursement levels for frames limit the choices of frames available to Medicaid eligibles.
- 1 pair of eyeglasses every 2 years for individuals 21 and over, unless there is a significant change in prescription or the individual has had cataract surgery.
- Experimental services are not covered.
- Recipients co-pay of $1.00 per service.

9. Outpatient Physical Therapy 10. Speech Therapy and 11. Occupational Therapy

- Ordered by physician.
- Limited to 200 visits/hours per year.
- Experimental services are not covered.
- Recipients co-pay of $1.00 per service.

12. Psychologist's Services

- Limited to 22 clinical hours per year.
- Collateral therapy with a parent is allowed for a child in active treatment. The time with the parent counts against the child's 22 hours.
- Experimental services including bio-feedback are not covered.
- Recipients co-pay of $1.00 per service.

13. Personal Care Attendant Services

- Ordered by physician.
- Must be medically necessary.
- Supervised by an RN.
- No skilled nursing services.
- May not be provided in a long term care facility, including a personal care facility.

- Cost of care may not exceed 80 percent of nursing home care unless prior authorization.

- Recipients co-pay of $1.00 per service.

14. Private Duty Nursing Services

- Ordered by a physician.

- Prior authorization.

- Recipients co-pay of $1.00 per service.

15. Clinic Services

- Under physician direction in a licensed facility for out-patients.

- Nursing home patients may be covered for mental health clinic services per approved agreement between center and nursing home. Reimbursement is made to the Mental Health Clinic by the department.

- Recipients co-pay of $1.00 per service.

16. Hearing Aids and Audiology Services

- Ordered by physician.

- Hearing evaluation by audiologist required prior to purchase.

- No replacements except for significant changes in hearing loss.

- Experimental services are not covered.

17. Medical Transportation

- Ambulances must be licensed under state law.

- Ambulances are covered for emergency care and for non-emergency care when the patient is stretcher-bound and the transport is ordered by a physician.

18. Prosthetic Devices

- Ordered by physician.

- Convenience and comfort items are not covered.

19. Emergency Hospital Services

20. Screening Services

- Experimental services not covered.

21. Inpatient Hospital for Age 65 or Older in Mental Institution

- See #1 "Mandatory Services"

22. SNF for Age 65 or Older in Mental Institution

- See #4 "Mandatory Services"

23. ICF for Age 65 or Older in Mental Institution

- See #4 "Optional Services"

24. ICF for Mentally Retarded

- See #4 "Mandatory Services"

25. SNF for Under Age 21

- See #4 "Mandatory Services"

26. Other Practitioner's Services